State: *Tennessee* ***Filing Company:*** *Dentegra Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *DIC, OHCR Group PPO TN, forms and rates*
Project Name/Number: */*

Filing at a Glance

Company:	Dentegra Insurance Company
Product Name:	DIC, OHCR Group PPO TN, forms and rates
State:	Tennessee
TOI:	H10G Group Health - Dental
Sub-TOI:	H10G.000 Health - Dental
Filing Type:	Form/Rate
Date Submitted:	06/14/2013
SERFF Tr Num:	DDPA-129066948
SERFF Status:	Assigned
State Tr Num:	H-130881
State Status:	Assigned - Pending Review
Co Tr Num:	DIC, OHCR GROUP PPO TN, FORMS AND RATES
Implementation Date Requested:	
Author(s):	Connie Roth, Sharon Ford, Cassandra Fiorito
Reviewer(s):	Vicky Stotzer (primary), Brian Hoffmeister, Melissa Merritt
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:
SG DEN SHOP P
OPGC-TN-DIC
SHOP small group dental plan

State: Tennessee **Filing Company:** Dentegra Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: DIC, OHCR Group PPO TN, forms and rates
Project Name/Number: /

General Information

Project Name:
Project Number:
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 06/17/2013
State Status Changed: 06/17/2013
Created By: Sharon Ford
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: These forms will not be used in our domiciliary state of Delaware; therefore, they have not been submitted to the Delaware Department of Insurance.
Market Type: Group
Group Market Size: Small
Overall Rate Impact:
Deemer Date:
Submitted By: Sharon Ford

Filing Description:

Enclosed for your review and approval are new group dental forms OPGC-TN-DIC et al. The primary form number is OPGC-TN-DIC. A complete listing of the forms included in this filing and the forms with which they are used is included at the end of this section.
These forms do not replace any forms on file with your Department. The forms will be used when our Dental PPO product is sold direct or by a partnership relationship to groups outside the Tennessee Federal Health Insurance Market Benefit Exchange. These products will use the Dentegra networks and will be marketed by licensed agents, brokers, third party administrators, mass marketed via various publications or online.

These plans provide the coverage for: the pediatric oral services required by the essential health benefits ('EHB') provisions; and for adult dental services ('Sup') required by the Affordable Care Act ('ACA'):
• Small Group/SHOP Pediatric and Supplemental High and Low Plans

Our effective date for use of these forms will be October 2013 when the Exchange is opened for business for coverage effective January 1, 2014, provided the filing has been approved by or deemed approved by your Department.

Text and numerical data in [brackets] is variable. Enclosed for your information are Variable Exhibits of these forms with comments for the variability. The comments explain what is variable and the various options that could be used. Any change or modification to a variable item outside the approved ranges will be submitted for prior approval.

Forms are:

Dental SHOP Pediatric High and Low Plans
OPGC-TN-DIC Contract
OPGE-TN-DIC Evidence of Coverage (EOC/certificate)

The following forms will be used with OPGC-TN- DIC and OPGE-TN- DIC:

OPGAtAhi-TN-DIC	Attachment A (Deductibles, Maximums and Contract Benefit Levels) – High Plan
OPGAtAlo-TN-DIC	Attachment A (Deductibles, Maximums and Contract Benefit Levels) – Low Plan
OPGAtB-TN-DIC	Attachment B (Services, Limitations and Exclusions)
OPGAtB1-DIC	Attachment B-1 (Schedule of Covered Services)

State: *Tennessee* **Filing Company:** *Dentegra Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *DIC, OHCR Group PPO TN, forms and rates*
Project Name/Number: */*

The following form will also be used with OPGC-TN- DIC
OPGAtC-TN-DIC Attachment C (Group Variables)

SHOP EHB and Supplemental High and Low Plans
OXGC-TN-DIC Contract
OXGE-TN-DIC Evidence of Coverage (EOC/certificate)

The following forms will be used with OXGC-TN- DIC and OXGE-TN- DIC:
OXGAtAhi-TN-DIC Attachment A (EHB Deductibles, Maximums and Contract Benefit Levels) – High Plan
OXGAtAlo-TN-DIC Attachment A (EHB Deductibles, Maximums and Contract Benefit Levels) – Low Plan
OXGAtB-TN-DIC Attachment B (EHB Services, Limitations and Exclusions)
OXGAtB1-DIC Attachment B-1 (EHB Schedule of Covered Services)
OXGAtChi-TN-DIC Attachment C (Sup Deductibles, Maximums and Contract Benefit Levels) – High Plan
OXGAtClo-TN-DIC Attachment C (Sup Deductibles, Maximums and Contract Benefit Levels) – Low Plan
OXGAtDhi-TN-DIC Attachment D (Sup Services, Limitations and Exclusions)- High Plan
OXGAtDlo-TN-DIC Attachment D (Sup Services, Limitations and Exclusions)- Low Plan
The following form will also be used with OXGC-TN-DIC
OXGAtE-TN-DIC Attachment E (Group Variables)

The following forms will be used with OPGC-TN-DIC, OPGE-TN-DIC,OXGC-TN-DIC and OXGE-TN-DIC:
Gap-TN-DIC -- Dental Application
HCR-ENRFM-TN-DIC -- Group Enrollment Form

Thank you for your attention to this filing. If you should need any additional information or have any questions, please do not hesitate to contact me at sford@dentegra.org or (770)641-5370.

Company and Contact

Filing Contact Information

Sharon Ford(Dentegra), Regulatory Analyst sford@dentegra.com
1130 Sanctuary Parkway, Ste 600 770-641-5370 [Phone]
Alpharetta, GA 30009 770-641-5193 [FAX]

Filing Company Information

Dentegra Insurance Company
100 First Street
San Francisco, CA 94105
(866) 714-7730 ext. [Phone]

CoCode: 73474
Group Code: 2479
Group Name: Dentegra Group, Inc.
FEIN Number: 75-1233841

State of Domicile: Delaware
Company Type: LAH
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$1,000.00
Retaliatory?	Yes
Fee Explanation:	Retaliatory Fee= $50.00 per form (20 Forms x $50.00= $1000.00)

State: *Tennessee* **Filing Company:** *Dentegra Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *DIC, OHCR Group PPO TN, forms and rates*
Project Name/Number: */*

Per Company: No

Company	Amount	Date Processed	Transaction #
Dentegra Insurance Company	$1,000.00	06/14/2013	71156488

SERFF Tracking #:	*DDPA-129066948*	***State Tracking #:***	*H-130881*	***Company Tracking #:***	*DIC, OHCR GROUP PPO TN, FORMS AND RATES*

State:	*Tennessee*	***Filing Company:***	*Dentegra Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*DIC, OHCR Group PPO TN, forms and rates*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: OPGC-TN-DIC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		PPO SHOP Pediatric Dental Contract	OPGC-TN-DIC	POL	Initial		43.200	OPGC-TN-DIC (Clean 6-11-13) .pdf
2		PPO SHOP Pediatric Dental Evidence of Coverage	OPGE-TN-DIC	CER	Initial		51.400	OPGE-TN-DIC (Clean 6-11-13).pdf
3		PPO SHOP Pediatric Dental Attachment A (Deductibles, Maximums and Contract Benefit Levels) – High Plan	OPGAtAhi-TN-DIC	OTH	Initial		57.900	OPGAtAhi-TN-DIC (Clean 6-5-13).pdf
4		PPO SHOP Pediatric Dental Attachment A (Deductibles, Maximums and Contract Benefit Levels) – Low Plan	OPGAtAlo-TN-DIC	OTH	Initial		57.900	OPGAtAlo-TN-DIC (Clean 6-5-13).pdf
5		PPO SHOP Pediatric Dental Attachment B (Services, Limitations and Exclusions)	OPGAtB-TN-DIC	OTH	Initial		51.900	OPGAtB-TN-DIC (Clean 6-5-13).pdf

SERFF Tracking #:	*DDPA-129066948*	***State Tracking #:***	*H-130881*	***Company Tracking #:***	*DIC, OHCR GROUP PPO TN, FORMS AND RATES*

State:	*Tennessee*	***Filing Company:***	*Dentegra Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*DIC, OHCR Group PPO TN, forms and rates*		
Project Name/Number:	*/*		

Lead Form Number: OPGC-TN-DIC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
6		PPO SHOP Pediatric Dental Attachment B-1 (Schedule of Covered Services)	OPGAtB1-DIC	OTH	Initial		54.300	OPGAtB1-DIC.pdf
7		PPO SHOP Pediatric Dental Attachment C (Group Variables)	OPGAtC-TN-DIC	POLA	Initial		45.200	OPGAtC-TN-DIC (Clean 6-5-13).pdf
8		PPO Group Combined/Integrated EHB and Sup Dental Contract	OXGC-TN-DIC	POL	Initial		47.500	OXGC-TN-DIC (Clean 6-12-13).pdf
9		PPO Group Combined/Integrated EHB and Sup Dental Evidence of Coverage	OXGE-TN-DIC	CER	Initial		53.000	OXGE-TN-DIC (Clean 6-12-13).pdf
10		PPO Group Combined Attachment A (EHB Deductibles, Maximums and Contract Benefit Levels) – High Plan	OXGAtAhi-TN-DIC	OTH	Initial		50.600	OXGAtAhi-TN-DIC (Clean 6-10-13).pdf
11		PPO Group Combined Attachment A (EHB Deductibles, Maximums and Contract Benefit Levels) – Low Plan	OXGAtAlo-TN-DIC	OTH	Initial		50.600	OXGAtAlo-TN-DIC (Clean 6-10-13).pdf

SERFF Tracking #:	*DDPA-129066948*	***State Tracking #:***	*H-130881*	***Company Tracking #:***	*DIC, OHCR GROUP PPO TN, FORMS AND RATES*

State:	*Tennessee*	***Filing Company:***	*Dentegra Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*DIC, OHCR Group PPO TN, forms and rates*		
Project Name/Number:	*/*		

Lead Form Number: OPGC-TN-DIC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
12		PPO Group Combined Attachment B (EHB Services, Limitations and Exclusions)	OXGAtB-TN-DIC	OTH	Initial		50.500	OXGAtB-TN-DIC (Clean 6-10-13).pdf
13		PPO Group Combined Attachment B-1 (EHB Schedule of Covered Services and Limitations)	OXGAtB1-TN-DIC	OTH	Initial		54.300	OXGAtB1-DIC.pdf
14		PPO Group Combined Attachment C (Sup Deductibles, Maximums and Contract Benefit Levels) - High Plan	OXGAtChi-TN-DIC	OTH	Initial		56.800	OXGAtChi-TN-DIC (Clean 6-10-13).pdf
15		PPO Group Combined Attachment C (Sup Deductibles, Maximums and Contract Benefit Levels) - Low Plan	OXGAtClo-TN-DIC	OTH	Initial		56.800	OXGAtClo-TN-DIC (Clean 6-10-13).pdf
16		PPO Group Combined Attachment D low (Sup Services, Limitations and Exclusions)	OXGAtDlo-TN-DIC	OTH	Initial		50.000	OXGAtDlo-TN-DIC (Clean 6-10-13).pdf

SERFF Tracking #:	*DDPA-129066948*	***State Tracking #:***	*H-130881*	***Company Tracking #:***	*DIC, OHCR GROUP PPO TN, FORMS AND RATES*

State: *Tennessee*
Filing Company: *Dentegra Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *DIC, OHCR Group PPO TN, forms and rates*
Project Name/Number: */*

Lead Form Number: OPGC-TN-DIC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
17		Group Dental Combined Attachment D high (Sup Services, Limitations and Exclusions)	OXGAtDhi-TN-DIC	OTH	Initial		50.000	OXGAtDhi-TN-DIC (Clean 6-10-13).pdf
18		PPO Group Combined Attachment E (Group Variables)	OXGAtE-TN-DIC	POLA	Initial		45.200	OXGAtE-TN-DIC (Clean 6-12-13).pdf
19		Group Dental Application	Gap-TN-DIC	AEF	Initial		0.000	Gap-TN-DIC .pdf
20		Group Dental Enrollment Form	HCR-ENRFM-TN-DIC	AEF	Initial		0.000	HCR-ENRFM-TN-DIC.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

DENTEGRA® INSURANCE COMPANY
[1130[D1] Sanctuary Parkway
Suite 600
Alpharetta, Georgia 30009
(877) 280-4204]

Group Dental PPO Insurance Contract

The Contractholder named in Attachment C Group Variables ("Attachment C") applied for a group dental insurance Contract with Dentegra Insurance Company ("Dentegra") [through[DS2] the Packaged Offering with the Medical Plan Issuer ("MPI"), [insert Medical Plan Issuer name]]. This Contract is underwritten by Dentegra Insurance Company ("Dentegra") and administered by Delta Dental Insurance Company. The following terms will apply:

I. [Contractholder[DS3] will pay the MPI or its third party administrator the monthly Premium stated in this Contract.]
[Contractholder[DS4] will pay Dentegra or its Third Party Administrator the monthly Premium stated in this Contract.]

II. When the Contractholder pays the first month's Premium, the term of this Contract will begin at 12:01 a.m. Standard Time, on the Effective Date listed in Attachment C. The term of this Contract will end as stated in this Contract at the end of the Contract Term at 12:00 midnight Standard Time.

III. [Contractholder will[CR5] provide each Employee with electronic access to a certificate/Evidence of Coverage booklet supplied by [Dentegra[DS6]/the MPI]. [Dentegra[DS7]/The MPI] will also furnish a hard copy to the Employee, Pediatric Enrollee or Contractholder upon request]. [Contractholder[D8] will provide each Employee a certificate/Evidence of Coverage booklet supplied by [Dentegra[DS9]/the MPI]. Contractholder will also distribute to its Employees any notice from [Dentegra[DS10]/the MPI] which may affect their child's rights under this Contract.

So long as Contractholder pays the Premiums stated in Article 3, Dentegra agrees to provide the Benefits described in this Contract including Attachment A Deductibles, Maximums and Contract Benefit Levels ("Attachment A"); Attachment B Services, Limitations and Exclusions ("Attachment B") and Attachment B-1 Schedule of Covered Services and Limitations ("Attachment B-1").

This Contract is issued and delivered in the State of Tennessee and is governed by its laws.

Anthony S. Barth, Vice Chairman

TABLE OF CONTENTS

ARTICLE 1
DEFINITIONS

Terms when capitalized in this document have defined meanings, given either in the section below or within the Contract sections.

1.01 **Accepted Fee --** the amount the attending Provider agrees to accept as payment in full for services rendered.

1.02 **Benefits** -- the amounts that Dentegra will pay for dental services under this Contract.

1.03 **Calendar Year** -- the 12 months of the year from January 1 through December 31.

1.04 **Claim Form** -- the standard form used to file a claim, request a Pre-Treatment Estimate or request Prior Authorization for medically necessary orthodontics.

1.05 **Contract** -- this agreement between Dentegra and Contractholder, including the attachments listed in Article 8.

1.06 **Contract Benefit Level** -- the percentage of the Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment A.

1.06 **Contractholder –** a small group employer named in Attachment C.

1.07 **Contract Term** -- the period during which this Contract is in effect, as shown in Attachment C.

1.08 **Contract Year** – the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

1.09 **Deductible** -- a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits as shown in Attachment A.

1.10 **Dentegra PPO℠ Provider (Dentegra Provider)** -- a Provider who contracts with Dentegra and agrees to accept Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO dental plan.

1.11 **Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee)** -- the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Enrollees.

1.12 **Eligible Pediatric Enrollee** – a person eligible for Benefits under Article 6

1.13 **Effective Date** -- the original date this Contract starts, as shown in Attachment C.

1.14 **Employee** – an individual employed by the Contractholder and who has opted to cover his/her child(ren) under this Contract.

1.15 **Maximum Contract Allowance --** the reimbursement under the Pediatric Enrollee's benefit plan against which Dentegra calculates its payment and the financial obligation for the Pediatric Enrollee. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided.

- by Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee;
- by Non-Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic area.

1.15 [**Medical**[DS11] **Plan Issuer ("MPI")** – the entity providing the medical plan that is issued and delivered to Contractholder with this dental plan as a Packaged Offering.]

1.16 **Non-Dentegra Provider --** a Provider who is not a Dentegra Provider and has not agreed to accept the Dentegra Provider's Contracted Fees.

1.17 **Open Enrollment Period** – the period of the year the [employer[DS12]/MPI] has established during which employees may change coverage selections for the next Contract Year.

1.18 **Out-of-Pocket Maximum** – the maximum amount a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from a Non-Dentegra Provider even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

1.19 [**Packaged**[DS13] **Offering** – the selection of a separate medical plan provided by the MPI bundled with this dental plan provided by Dentegra.]

1.20 **Patient Pays** – the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

1.21 **Pediatric Enrollee** – an Eligible Pediatric Enrollee enrolled to receive Benefits; may also be referred to as "Enrollee".

1.22 **Pediatric Enrollee's Effective Date of Coverage** – the date the [Contractholder[DS14]/MPI] reports coverage will begin for each Pediatric Enrollee.

1.23 **Premium** -- the amounts payable by the Contractholder monthly as provided in Attachment C.

1.24 **Pre-Treatment Estimate** -- an estimation of the allowable Benefits under this Contract for the services proposed, assuming the person is an eligible Pediatric Enrollee.

1.25 **Procedure Code** – the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

1.26 **Program Allowance** -- the amount determined for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

1.27 **Provider** -- a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

1.28 **Qualifying Status Change** -- a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of employee);
- dependent child ceases to satisfy eligibility requirements;
- residence (Employee or child moves);
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

1.29 **Single Procedure** -- a dental procedure that is assigned a separate Procedure Code.

1.30 **Submitted Fee** -- the amount that the Provider bills and enters on a claim for a specific procedure.

ARTICLE 2
CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

2.01 Dentegra will pay Benefits for dental services described in Attachments B and B-1 when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and exclusions will be applied for the period the person enrolled under any Dentegra program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional waiting periods, if any, are shown in Attachment A.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

2.02 Dentegra's provision of Benefits is limited to the applicable portion of the Provider's fees or allowances specified in Attachment A for Diagnostic and Preventive, Basic, Major, and Medically Necessary Orthodontic Services. The financial obligation for the Pediatric Enrollee is responsible for paying the balance of any fees or allowances known as "Coinsurance". Contractholder has chosen to require Coinsurances under this program as a method of sharing the costs of providing dental Benefits to Pediatric Enrollees. If the Provider discounts, waives or rebates any portion of the Coinsurance to the Pediatric Enrollee, Dentegra will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of such Coinsurance fees or allowances that are discounted, waived or rebated.

2.03 **Deductible**
Dentegra will not pay Benefits for services received each Calendar Year by a Pediatric Enrollee until the Deductible, as shown in Attachment A, has been satisfied. The annual Deductible per family, if any, is shown in Attachment A. Only fees paid for covered services will count toward the Deductible.

2.04 **Coordination of Benefits**

Dentegra coordinates the Benefits under this Contract with a Pediatric Enrollee's benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. If this Contract is the "primary" plan, Dentegra will not reduce Benefits. If this is the "secondary" plan, Dentegra may reduce Benefits otherwise payable under this Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

Order of Benefit Determination Rules:

The following rules determine which plan is the "primary" plan:

(1) Except as stated in paragraph (2), when this plan and another plan cover the same child as a dependent of different persons, called parents:
   a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
   b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
   c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(2) In the case of a dependent child of legally separated or divorced parents, the plan covering the Pediatric Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Pediatric Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

(3) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (1).

(4) If none of the above rules determine the order of benefits, the benefits of the plan which covered a Pediatric Enrollee longer are determined before those of the plan which covered that insured person for the shorter term.

(5) When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

2.06 **Clinical Examination**

Before approving a claim, Dentegra may obtain, to such extent as may be lawful, from any Provider, or from hospitals in which a Provider's care is provided, such information and records relating to a Pediatric Enrollee as Dentegra may require to administer the claim. Dentegra, at its own expense, may also require that a Pediatric Enrollee be examined by a dental consultant retained by Dentegra, as often as necessary, in or near his/her community or residence while a claim is pending. Such information and records will be kept confidential in accordance with all applicable laws and regulations.

2.07 **Notice of Claim Forms**

Dentegra will furnish to any Provider or Pediatric Enrollee, on request, a Claim Form to make a claim for payment of Benefits. To make a claim, the Claim Form must be completed and signed by the Provider who performed the services and by the Pediatric Enrollee (or the parent or guardian of a minor) and submitted to Dentegra at the address shown thereon. If Dentegra does not furnish the form within 15 days after requested by a Provider or Pediatric Enrollee, the requirements for proof of loss set forth in section 2.09 of this Contract will be deemed to have been complied with upon the submission to Dentegra within the time established in said section for filing proof of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. Pediatric Enrollees may download a Claim Form from Dentegra's website.

2.08 **Prior Authorization for Medically Necessary Orthodontics**

Orthodontic treatment is covered under this Contract, which are shown in Attachments A, B and B-1, only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

2.09 **Pre-Treatment Estimates**

A Provider may file a Claim Form before treatment, showing the services to be provided to a Pediatric Enrollee. Dentegra will estimate the amount of Benefits payable under this Contract for the listed services. Benefits will be processed according to the terms of this Contract when the treatment is performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date this Contract terminates;
- the date Benefits under this Contract are amended if services in the Pre-Treatment Estimate are part of the amendment;
- the date the Pediatric Enrollee's coverage ends; or
- the date the Provider's agreement with Dentegra ends.

2.10 **Written Notice of Claim/Proof of Loss**

Dentegra must be given a written notice of claim, sometimes referred to as a written proof of loss, within 12 months after the date of the loss and must include information regarding other group coverage if applicable. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one (1) year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Dentegra within 12 months of the termination of this Contract.

2.11 **Time of Payment**

Claims payable under this Contract for any loss other than for which this Contract provides any periodic payment will be paid no later than 30 days after written proof of loss is received. Dentegra will notify the Pediatric Enrollee and his/her Provider of any additional information needed to process the claim within this 30 day period.

2.12 **Claims Appeal**

Dentegra will notify the Pediatric Enrollee and his/her Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Pediatric Enrollee has at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to Dentegra giving reasons why they believe the denial was wrong. The Pediatric Enrollee and his/her Provider may also ask Dentegra to examine any additional information provided that may support the appeal or grievance.

Send appeal or grievance to Dentegra at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Dentegra will send the Pediatric Enrollee a written acknowledgment within five (5) days upon receipt of the appeal or grievance. Dentegra will make a full and fair review within 30 days after Dentegra receives the complaint, grievance or appeal. Dentegra may ask for more documents if needed. Dentegra will send the Pediatric Enrollee a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Contract, Dentegra shall consult with a Dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. Dentegra will send the Pediatric Enrollee a decision within 30 days after receipt of the Pediatric Enrollee's appeal or grievance.

If the Pediatric Enrollee believes he/she needs further review of their appeal or grievance, he/she may contact his/her state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Pediatric Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Pediatric Enrollee may also bring a civil action under Section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

2.13 **To Whom Benefits Are Paid**

Payment for services provided by a Dentegra Provider will be made directly to the Provider. Any other payments provided by this Contract will be made to the Pediatric Enrollee unless the Pediatric Enrollee requests when filing proof of loss that the payment be made directly to the Provider providing the services. All Benefits not paid to the Provider will be payable to the Pediatric Enrollee, to his/her estate, or to an alternate recipient as directed by court order except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

2.14 No change in Benefits will become effective during a Contract Term unless Contractholder and Dentegra agree in writing.

ARTICLE 3
REPORTING AND MONTHLY PREMIUMS

3.01 **Reporting**
Dentegra processes eligibility as reported by the [Contractholder[DS15]/MPI].

Contractholder is responsible for notifying [Dentegra[DS16]/the MPI] with additions, changes or terminations made during the prior month as required by [Dentegra[DS17]/the MPI]. A Pediatric Enrollee remains enrolled until the Contractholder notifies [Dentegra[DS18]/the MPI] of the termination. If the Pediatric Enrollee loses coverage or makes any change that affects eligibility, Contractholder must promptly notify [Dentegra[DS19]/the MPI] of such change.

Dentegra will not make any payment for services provided to a Pediatric Enrollee who is not reported to Dentegra as eligible under this Contract when the service is provided. Also, Dentegra may not pay Benefits for a Pediatric Enrollee if Premiums are not paid for the month in which dental services are rendered. Dentegra shall not be obligated to recover claims paid to a Provider as a result of Contractholder's retroactive eligibility adjustments. The Contractholder agrees to reimburse Dentegra for any erroneous claim payments made by Dentegra as a result of incorrect eligibility reporting by the Contractholder to [Dentegra[DS20]/the MPI].

Retroactive[DS21] premium adjustments are limited to the immediately preceding three (3) months plus the current billing month.

3.02 Contractholder will permit Dentegra to audit Contractholder's records to confirm compliance with Articles 3 and 6. Dentegra will give Contractholder written notice within a reasonable time before the audit date.

3.03 [Contractholder [D22]will remit to the MPI or its third party administrator the Premium in the amount and manner shown in Attachment C for all Pediatric Enrollees.] [Contractholder [D23]will remit to Dentegra or its Third Party Administrator the Premium in the amount and manner shown in Attachment C for all Pediatric Enrollees.]

For[DS24] enrollment additions, Contractholder will remit a full month's Premium for Pediatric Enrollees whose coverage is effective on the first through the fifteenth calendar day of a month. Premiums are not due to Dentegra for Pediatric Enrollees who are enrolled on the sixteenth through the last day of a month.]

For[DS25] enrollment terminations, Contractholder will remit a full month's Premium for Pediatric Enrollees whose coverage is terminated on the sixteenth through the last calendar day of a respective month. Premiums are not due to Dentegra for Pediatric Enrollees whose enrollment is terminated on the first through the fifteenth day of a month.]

3.04 This Contract will not be in effect until Dentegra receives the first month's Premiums. Subsequent Premiums will be paid by the first day of each month. For each Premium after the first, a grace period of 31 days from the due date will be allowed for the payment of the Premium. This Contract will continue in force during this period; if the Premium remains unpaid at the end of the grace period, this Contract may be terminated by Dentegra in accordance with the notice requirements of section 4.01. Any payment received after 90 days of the due date shall be subject to interest charges at an annualized rate equal to one percentage point above the then current three (3) month U.S. Treasury Bill rate, which interest shall commence accruing as of the first day following the end of the 31 day grace period.

3.05 If this Contract is terminated before the end of a Contract Term, Contractholder will pay additional charges in accordance with Article 4.

3.06 Dentegra will not be responsible or liable for any incorrect, incomplete, obsolete or unreadable data or information supplied to Dentegra including, but not limited to, eligibility and enrollment information.

3.07 Dentegra may change the monthly Premium whenever this Contract is amended as stated in section 3.08, or whenever the Contractholder requests a change in Benefits, eligibility or when due to a state and/or federal mandated change. Any change in Premium shall not be effective during a Contract Term unless Contractholder and Dentegra agree in writing, except as provided in section 3.08 or a state and/or federal mandated change.

3.08 If during the Contract Term any new or increased tax, assessment, or fee is imposed on the amounts payable to, or by, Dentegra under this Contract or any immediately preceding contract between Dentegra and Contractholder, the Premium amount stated in Attachment C will be increased by the amount of any such new or increased tax, assessment, or fee by written notice to Contractholder, and this Contract shall thereby be modified on the date set forth in the notice.

ARTICLE 4
TERMINATION AND RENEWAL

4.01 This Contract may be terminated only as follows:

- By Dentegra upon 31 days written notice if Contractholder fails to pay Premiums, in the amount and manner required by Article 3.
- By Contractholder or Dentegra at the end of a Contract Term upon 60 days written notice.
- [By[DS26] Dentegra as of the termination date of the bundled medical plan as notified by the MPI.]

4.02 In the event this Contract is terminated under section 4.01 first bullet item, Contractholder will become immediately obligated upon termination to pay Dentegra for that portion of the monthly Premium which constitutes for the current Contract Term Dentegra's direct costs of administering this Contract (calculated by subtracting the pure Premium from the total Premium) multiplied by the remaining number of months from the date of termination to the expiration of the current Contract Term, but the amount will not exceed 25 percent of the total Premium for the entire Contract Term.

4.03 If Dentegra if notified that the Contractholder intends to terminate this Contract upon less than 60 days notice, Section 4.02 will apply as if Dentegra terminated this Contract under section 4.01 first bullet.

4.04 Dentegra will not be required to do Pre-Treatment Estimates if this Contract is terminated for any cause nor will Dentegra be required to pay for services performed beyond the termination date except for completion of Single Procedures commenced while this Contract was in effect as stated in section 7.04.

4.05 [Contractholder[DS27] will receive renewal information from the MPI prior to any applicable Open Enrollment Period. Provided Dentegra continues to make this policy available through the MPI at the renewal period, Contractholder may elect to continue to offer this Contract to Eligible Pediatric Enrollees, subject to the applicable Premium available through the MPI for this plan at the time of renewal.]

[Dentegra[DS28] will provide [60][d29] days advance written renewal notice prior to the end of the initial or any subsequent Contract Terms indicating if Premiums and/or Benefits will remain the same or change. The Contractholder's payment of the Premium indicated in the renewal notice for the new Contract Term will signify the Contractholder's acceptance of the renewal. If the Contractholder fails to provide written notification to Delta Dental of non-renewal by the date indicated in the renewal letter and/or does not pay the Premiums indicated in the renewal notice with the new Contract Term, Delta Dental will terminate this Contract under section 4.01 first bullet.]

ARTICLE 5
GENERAL PROVISIONS

5.01 **Entire Contract: Changes**
This Contract, including the attachments listed in Article 12, is the entire agreement between the parties. No agent has authority to change this Contract or waive any of its provisions. No change in this Contract will be valid unless approved by an executive officer of Dentegra.

5.02 **Severability**
If any part of this Contract or an amendment of it is found by a court or other authority to be illegal, void or not enforceable, all other portions of this Contract will remain in full force and effect.

5.03 **Conformity With State Laws**
All legal questions about this Contract will be governed by the state of Tennessee where this Contract was entered into and is to be performed. Any part of this Contract which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

5.04 **Misstatements on Application; Effect**
In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of this Contract, all statements made by the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Contract, unless it is contained in a written instrument signed by the Contractholder, a copy of which has been furnished to such Contractholder.

5.05 **Legal Actions**
No action at law or in equity will be brought to recover on this Contract before 60 days after written proof of loss has been furnished in accordance with requirements of this Contract; nor will an action be brought after the expiration of three (3) years after the time written proof is required to be furnished.

5.06 **Not in Lieu of Workers' Compensation**
This Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

5.07 **Certificate of Insurance**
[[Dentegra[CR30]/MPI] will issue to the Contractholder an electronic file containing a certificate/EOC summarizing the Benefits to which Pediatric Enrollees are entitled and to whom Benefits are payable. Each Employee with children enrolled under this Contract will have electronic access to the certificate.[[Dentegra[DS31]/The MPI] will also furnish a hard copy to the Employee, Pediatric Enrollee or Contractholder upon request]. [[Dentegra[D32]/The MPI] will issue to the Contractholder for delivery to each Employee with a child enrolled under this Contract a certificate/EOC booklet summarizing the Benefits to which Pediatric Enrollees are entitled and to whom Benefits are payable]. The certificate is not assignable and the Benefits are not assignable prior to a claim. If any amendment to this Contract will materially affect any Benefits described in the certificate, new certificates or amendments showing the change will be issued.

5.08 **Publications About Program**
Contractholder and Dentegra agree to consult as is reasonably practical on all material published or distributed about this Contract. No material will be published or distributed which conflicts with the terms of this Contract.

5.09 **Provider Relationship**
Contractholder and Dentegra agree to permit and encourage the professional relationship between Provider and Pediatric Enrollee to be maintained without interference. Any Dentegra or Non-Dentegra Provider, including any Provider or employee associated with or employed by them, who provides dental services to Pediatric Enrollees does so as an independent contractor and shall be solely responsible for dental advise and for performance of dental services, or lack thereof, to the Pediatric Enrollee.

5.10 **Notice; Where Directed**
All formal notice under this Contract must be in writing and sent by email, facsimile (fax), first-class United States mail, overnight delivery service, or personal delivery. Notice by United States mail will be effective 48 hours after mailing with fully prepaid postage.

Contractholder shall designate in writing a representative for purposes of receiving notices from Dentegra under this Contract. Contractholder may change its representative at any time with 30 days written notice to Dentegra. The Contractholder's representative shall disseminate notices to the Pediatric Enrollees within 30 days of receipt.

5.11 **Indemnification**
Contractholder will indemnify, defend and hold harmless Dentegra, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Contractholder's negligent performance or non-performance of its obligations under this Agreement.

Dentegra will indemnify, defend and hold harmless Contractholder and its employees and agents, against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Dentegra's negligent performance or non-performance of its obligations under this Agreement.

5.12 **Time Limit On Certain Defenses**
After this Contract has been in force for two (2) years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an Employee or Pediatric Enrollee with respect to the Pediatric Enrollee's insurability, will be used to reduce or deny a claim or contest the validity of insurance for such Pediatric Enrollee after that person's coverage has been in effect two (2) years or more during his or her lifetime.

5.13 **Compliance with Administrative Simplification, Security and Privacy Regulations**
Contractholder and Dentegra shall comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable Pediatric Enrollee information including executing a Business Associate Addendum as required by Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Contractholder and Dentegra agree that this Contract shall incorporate terms as necessary and as applicable to execute the required agreements (i.e. business associate agreement) to comply with federal regulations issued under the HIPAA, HITECH Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

5.14 **Impossibility of Performance**
Neither party shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires, or unusually severe weather. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

5.15 **Third Party Administrator ("TPA")**
Dentegra may use the services of a TPA, duly registered under applicable state law, to provide services under this Contract. Any TPA providing such services or receiving such information shall enter into a separate Business Associate Agreement with Dentegra providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Pediatric Enrollees.

5.16 **Mutual Confidentiality**
Contractholder and Dentegra agree to maintain confidential information using the same degree of care (which shall be no less than reasonable care) as each uses to protect its own confidential information of a similar nature and to use confidential information only for specified purposes. Confidential information includes any information which the owner deems confidential, whether marked as confidential or otherwise clearly identifiable as confidential and includes information not generally known by the public or by parties which are competitive with or otherwise in an industry, trade or business similar to the owner of the confidential information. The recipient of confidential information shall notify the owner of any unauthorized disclosure or breach of confidentiality as soon as possible after discovery and without unreasonable delay.

5.17 **Trademarks; Service Marks**
Unless specifically allowed in this Contract, neither party shall use the name, trademarks, service marks or other proprietary branding of the other party without the advance written approval of the other party.

ARTICLE 6
ELIGIBILITY AND ENROLLMENT

6.01 **Eligible Pediatric Enrollee**
Eligible Pediatric Enrollees are dependent children of Employees to whom Contractholder offers coverage. Such dependent children are eligible for Benefits under this Contract from birth to age 26.

Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulations and as may be recognized by the Contractholder.

Pediatric Enrollees on active military duty are not eligible.

6.02 **Enrollment of Eligible Pediatric Enrollees**
The [Contractholder[DS33]/MPI] is responsible for establishing the Pediatric Enrollee's Effective Date of Coverage for enrollment. Eligible Pediatric Enrollees must be enrolled within [31[d34]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS35] Pediatric Enrollees who enroll in the Contractholder's medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

6.03 Except for an Employee absent from work due to a leave of absence governed by the "Family & Medical Leave Act of 1993" (P.L. 103.3), a Pediatric Enrollee will not be covered for any dental services received while an Employee is on strike, lay-off or leave of absence. Contractholder must inform the [Dentegra[DS36]/MPI] of any change in eligibility as required under section 3.01.

Coverage will resume the first day of the month after the Employee returns to work, provided the Contractholder submits the request to [Dentegra[DS37]/the MPI] that coverage be reactivated.

Benefits for such Pediatric Enrollee will resume as follows:
- If coverage is reactivated in the same Calendar Year, Deductibles and Out-of-Pocket Maximums for the Pediatric Enrollee will resume as if the Employee was never gone.
- If coverage is reactivated in a different Calendar Year, new Deductibles and Out-of-Pocket Maximums will apply.

If an Employee is rehired within the same Calendar Year, Deductibles and Out-of-Pocket Maximums will resume as if the Employee was never gone.

6.04 Coverage will terminate when a Pediatric Enrollee loses dependent status or reaches age 26.

Termination of Benefits on Loss of Eligibility
Dentegra will not pay for Benefits for any services received by a person who is not a Pediatric Enrollee at the time of treatment except for covered dental services incurred when the person was covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:
- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

6.05 **Continuation of Coverage Under COBRA**
When the employees of a Contractholder are covered under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), then in consideration of the payments specified in Article 3, Dentegra agrees to provide Benefits to Pediatric Enrollees for whom continued coverage is elected pursuant to this section, provided:
- continuation of coverage is required to be offered under COBRA;
- the Pediatric Enrollee requests the continuation within the time frame allowed;

- the Contractholder notifies [Dentegra[DS38]/the MPI] that the Pediatric Enrollee has elected to continue coverage under COBRA;
- Dentegra receives the required Premium for the continued coverage;
- this Contract stays in force.

Dentegra does not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

ARTICLE 7
CHOICE OF PROVIDERS FOR PEDIATRIC BENEFITS

7.01 Pediatric Enrollees may choose a Provider from Dentegra's panel of PPO Providers or Pediatric Enrollees may choose a Non-Dentegra Provider. A list of Providers can be obtained by accessing the Dentegra Provider directory at [dentegra.com]. A representative can provide specific Provider information over the phone or by mail. Pediatric Enrollees are responsible for verifying whether the selected Provider is a Dentegra Provider. Additionally, Pediatric Enrollees should always confirm with the Provider's office that a listed Provider is still a participating Dentegra Provider. Dentegra does not guarantee that any particular Provider will be available.

Dentegra Provider
Selecting a Dentegra Provider potentially allows the greatest reduction in Pediatric Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon. Also, the services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A.

Non-Dentegra Provider
If a Provider is a Non-Dentegra Provider, the amount charged to Pediatric Enrollees may be above that accepted by the Dentegra Providers, and Pediatric Enrollees will still be responsible for Coinsurance and other cost-sharing, including balance billed amounts, after the Out-of-Pocket Maximum is met. Costs incurred by the patient with a Non-Dentegra Provider do not count towards the Out-of-Pocket Maximum. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

Additional advantages of using a Dentegra Provider:
- The Dentegra Provider must accept assignment of Benefits, meaning Dentegra Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Pediatric Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra Provider's Contracted Fee.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

ARTICLE 8
ATTACHMENTS

These documents are attached to this Contract and made a part of it:

Attachment A Deductibles, Maximums and Contract Benefit Levels
Attachment B Services, Limitations and Exclusions
Attachment B-1 Schedule of Covered Services and Limitations
Attachment C Group Variables

[logo[D1]]

Dentegra® Dental PPO

Children's [Plan 70/Plan 85[D2]]

Group Name[DR3]

Group No.[DR4]

Effective Date[DR5]

[Revised][DR6]

Provided by:

Dentegra Insurance Company

variable text – highlight & delete if not needed
variable text – highlight & delete if not needed

[dentegra[D7].com]

[MPI website and phone number[D8]]

Table of Contents

Attachments

INTRODUCTION

Your employer has chosen Dentegra® Insurance Company ("Dentegra") to meet your dental insurance needs. This plan is underwritten by Dentegra and administered by Delta Dental Insurance Company. Our goal is to provide the Pediatric Enrollees with the highest quality dental care and to help him/her maintain good dental health. We encourage Pediatric Enrollees not to wait until there is a problem to see the Provider, but to see him/her on a regular basis.

Using This Evidence of Coverage - This Evidence of Coverage booklet, which includes Attachment A Deductibles, Maximums and Contract Benefit Levels ("Attachment A") and Attachment B Services, Limitations and Exclusions ("Attachment B") and Attachment B-1 Schedule of Covered Services and Limitations ("Attachment B-1"), discloses the terms and conditions of Pediatric Enrollee's coverage and is designed to help he/she make the most of their dental plan. It will help the Employee and/or the Pediatric Enrollee understand how the plan works and how the Pediatric Enrollee may obtain dental care. Please read this booklet completely and carefully. Keep in mind that "you" and "your" mean the Enrollees who are covered. "We," "us" and "our" always refer to Dentegra. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Contract.

The benefit explanations contained in this booklet are subject to all provisions of the Contract on file with the employer ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Notice: *This booklet is a summary of your group dental program and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.*

Contact Us

For more information please visit our website at[D9] [dentegra.com] or call our Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at [877-280-4204] [D10]to obtain information about your eligibility, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850][D11]

Anthony S. Barth, Vice Chairman

DEFINITIONS

Terms when capitalized in this Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits: the amounts that Dentegra will pay for dental services under the Contract.

Calendar Year: the 12 months of the year from January 1 through December 31.

Claim Form: the standard form used to file a claim or request Pre-Treatment Estimate or request Prior Authorization for medically necessary orthodontics.

Contract: the agreement between Dentegra and the Contractholder, including any attachments.

Contract Benefit Level -- the percentage of the Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment A.

Contractholder: a small group employer named on this booklet's cover.

Contract Term: the period during which the Contract is in effect.

Contract Year: the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Deductible -- a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits as shown in Attachment A.

Dentegra PPO℠ Provider (Dentegra Provider): a Provider who contracts with Dentegra and agrees to accept Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO dental plan.

Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee): the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Pediatric Enrollees.

Effective Date: the original date the contract starts. This date is given on this booklet's cover.

Eligible Pediatric Enrollee: a person eligible for Benefits under the Contract.

Employee: an individual employed by the Contractholder and who has opted to cover his/her child(ren) under the Contract.

Maximum Contract Allowance: the reimbursement under the Pediatric Enrollee's benefit plan against which Dentegra calculates its payment and the financial obligation for the Pediatric Enrollee. Subject to adjustment for extreme difficulty or unusual circumstance, the Maximum Contract Allowance for services provided:

- by Dentegra Providers is the lesser of the Submitted Fee on the claim or the Dentegra Provider's Contracted Fee; or
- by Non-Dentegra Providers is the lesser of the Submitted Fee on the claim or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic area.

[**Medical**[DS12] **Plan Issuer ("MPI"):** the entity providing the medical plan that is issued and delivered to Contractholder with this dental plan as a Packaged Offering.]

Non-Dentegra Provider: a Provider who is not a Dentegra Provider and has not agreed to accept the Dentegra Provider's Contracted Fees.

Open Enrollment Period: the period of the year that the [employer[DS13]/MPI] has established during which Employees may change coverage selections for the next Contract Year.

Out-of-Pocket Maximum: the maximum amount a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including

balance billed amounts, will continue to apply for covered services from Non-Dentegra Provider even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

[**Packaged**[DS14] **Offering:** the selection of a separate medical plan provided by the MPI bundled with this dental plan provided by Dentegra.]

Patient Pays: the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

Pediatric Enrollee: an Eligible Pediatric Enrollee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee".

Pediatric Enrollee's Effective Date of Coverage: the date the [Contractholder[DS15]/MPI] reports coverage will begin for each Pediatric Enrollee.

Pre-Treatment Estimate: an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an Eligible Pediatric Enrollee.

Procedure Code: the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

Program Allowance: the amount determined for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Qualifying Status Change: a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of Employee);
- dependent child ceases to satisfy eligibility requirements;
- residence (Employee or child moves);
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

Single Procedure: a dental procedure that is assigned a separate procedure code.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

PREMIUMS:

The Employee may be required to contribute towards the cost the Pediatric Enrollee's coverage.

We may cancel the Contract 31 days after written notice to the Contractholder if monthly premiums are not paid when due.

ELIGIBILITY AND ENROLLMENT

Eligible Pediatric Enrollee

Eligible Pediatric Enrollees are dependent children of employees to whom Contractholder offers coverage. Such dependent children are eligible for Benefits under the Contract from birth to age 26.

Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by the applicable state regulations and as may be recognized by the Contractholder.

Pediatric Enrollees serving on active military duty are not eligible.

Enrollment of Eligible Pediatric Enrollees

The [Contractholder[DS16]/MPI] is responsible for establishing Pediatric Enrollee's Effective Date of Coverage for enrollment. Eligible Pediatric Enrollees must be enrolled within [31[d17]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS18] Pediatric Enrollees who enroll in the Contractholder's medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

Coverage will terminate when a Pediatric Enrollee loses dependent status or reaches age 26.

Continuation of Benefits

We will not pay for any services/treatment received after the Pediatric Enrollee's coverage ends. However, we will pay for covered services incurred while he/she were eligible if the procedures were completed within 31 days of the date his/her coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence

Pediatric Enrollees will not be covered for any dental services received while the Employee is on strike, lay-off, leave of absence, other than as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Coverage will resume the first day of the month after the Employee returns to work, provided the Contractholder submits the requests to [Dentegra[D19]/the MPI] that coverage be reactivated.

Benefits for Pediatric Enrollees will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and Out-of-Pocket Maximums will resume for the Pediatric Enrollee as if the Employee was never gone.
- If coverage is reactivated in a different Calendar Year, new Deductibles and Out-of-Pocket Maximums will apply.
- If an Employee is rehired within the same Calendar Year, Deductibles and Out-of-Pocket Maximums for the Pediatric Enrollee will resume as if the Employee was never gone.

*Coverage for Pediatric Enrollees is not affected if the Employee takes a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If the Employee is currently paying any part of the premium, he/she may choose to continue coverage. If the Employee does not continue coverage

during the leave, he/she can resume coverage for Pediatric Enrollees on their return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act does not apply to all companies, only those that meet certain size guidelines. See the Human Resources Department for complete information.

Continuation of Coverage Under COBRA
COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for the Pediatric Enrollee who loses employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA.

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

We will pay Benefits for the types of dental services described in Attachment B and Attachment B-1. We will pay Benefits only for covered services. The Contract covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and exclusions will be applied for the period the person is an Enrollee under any Dentegra program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional waiting periods, if any, are listed in Attachment A.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services as shown in Attachment A, and the balance is the financial obligation for the Pediatric Enrollee. The balance is called the coinsurance (“Coinsurance”) and is part of his/her out-of-pocket cost. Coinsurance is paid even after a Deductible has been met.

The amount of Coinsurance will depend on the type of service and the Provider providing the service (see section titled “Selecting Your Provider”). Providers are required to collect Coinsurance for covered services. The Employee’s group has chosen to require Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Pediatric Enrollees. If the Provider discounts, waives or rebates any portion of the Coinsurance, we will be obligated to provide as Benefits only the applicable percentages of the Provider’s fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to the Pediatric Enrollee’s advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for him/her. Please refer to the sections titled “Selecting Your Provider” and “How Claims Are Paid” for more information.

Deductible

A Deductible is an amount that must paid on behalf of the Pediatric Enrollee before Benefits are paid. The Deductible amounts, if any, are listed in Attachment A. Deductibles apply to all benefits unless otherwise noted. Only fees paid for covered Benefits will count toward the Deductible.

Prior Authorization for Medically Necessary Orthodontics

Orthodontic treatment is covered only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization ("Prior Authorization") is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, the Pediatric Enrollee's Provider may file a Claim Form before beginning treatment, showing the services to be provided to the Pediatric Enrollee. We will estimate the amount of Benefits payable under the Contract for the listed services. By asking his/her Provider for a Pre-Treatment Estimate from us before the Pediatric Enrollee receives any prescribed treatment, we will provide an estimate up front of what we will pay and the difference is the financial obligation of the Pediatric Enrollee. The Benefits will be processed according to the terms of the Contract when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date Benefits under the Contract are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date the Pediatric Enrollee's coverage ends; or
- the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if the Pediatric Enrollee is enrolled and meets all the requirements of the program at the time the treatment planned is completed and may not take into account any Deductibles, so please remember to figure in the Pediatric Enrollee's Deductible if necessary.

Coordination of Benefits

We coordinate the Benefits under the Contract with the Pediatric Enrollee's benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. If this plan is the "primary" plan, we will not reduce Benefits. If this plan is the "secondary" plan, we may reduce Benefits otherwise payable under the Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

- How do we determine which Plan is the "primary" plan?
  (1) Except as stated in paragraph (2), when this plan and another plan cover the same child as a dependent of different persons, called parents:
    a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
    b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
    c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
  (2) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.
  (3) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (1) under the first bullet.

(4) When determination cannot be made in accordance with the above, the benefits of the plan which covered the Pediatric Enrollee longer are determined before those of the plan which has covered the Pediatric Enrollee for the shorter term.

(5) When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

SELECTING YOUR PROVIDER

Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support the right to freedom of choice regarding the Pediatric Enrollee's Provider. Freedom of choice assures that the Pediatric Enrollee has full access to the dental treatment they need from the dental office of his/her choice. The Pediatric Enrollee may see any Provider for his/her covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider. In addition, family members can see different Providers.

Remember, Pediatric Enrollees enjoy the greatest Benefits—including out-of-pocket savings—when they choose a Dentegra Provider. To take full advantage of the dental plan, we highly recommend the Pediatric Enrollee verify a dentist's participation status within a Dentegra network with his/her dental office before each appointment. Review the section titled "How Claims Are Paid" for an explanation of Dentegra payment procedures to understand the method of payments applicable to his/her Dentist selection and how that may impact his/her out-of-pocket costs.

Locating a Dentegra Provider

There are two ways in which the Pediatric Enrollee can locate a Dentegra Provider in his/her area:

- Pediatric Enrollees may access information through our website at [dentegra.com]. This website includes a Provider search function allowing the Pediatric Enrollee to locate Dentegra Providers by location, specialty and network type; or
- Pediatric Enrollees may also call our Customer Service Center toll-free at [877-280-4204] and one of our representatives will assist them. We can provide the Pediatric Enrollee with information regarding a Provider's network, specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — Dentegra Provider

Payment for covered services performed for the Pediatric Enrollee by a Dentegra Provider is calculated based on the Maximum Contract Allowance. The services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A. Dentegra Providers have agreed to accept the Dentegra Provider's Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A. Dentegra's payment is sent directly to the Dentegra Provider who submitted the claim. We advise the Pediatric Enrollee of any charges not payable by us for which they are responsible. These charges are generally the Pediatric Enrollee's share of the Maximum Contract Allowance, as well as any Deductibles and/or charges for non-covered services.

Payment for Services — Non-Dentegra Provider

Payment for services performed for the Pediatric Enrollee by a Non-Dentegra Provider is also calculated based on the Maximum Contract Allowance. The amount charged to the Pediatric Enrollee may be above that accepted by the Dentegra Providers and Pediatric Enrollees will still be responsible for Coinsurance and other cost-sharing, including balance billed amounts, after the Out-of-Pocket Maximum is met. Costs incurred by the Pediatric Enrollee with a Non-Dentegra Provider do not count towards the Out-of-Pocket Maximum. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in

Attachment A. Non-Dentegra Providers have no agreement with Dentegra and are free to bill the Pediatric Enrollee for any difference between what Dentegra pays and the Submitted Fee.

When dental services are received from a Non-Dentegra Provider, Dentegra's payment is sent directly to the Pediatric Enrollee , unless he/she has assigned the Benefits to the Provider. The Pediatric Enrollee is responsible for payment of the Non-Dentegra Provider's Submitted Fee. Non-Dentegra Providers will bill the Pediatric Enrollee for his/her normal charges, which may be higher than the Maximum Contract Allowance for the service. The Pediatric Enrollee may be required to pay the Provider and then submit a claim to us for reimbursement. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A. Since our payment for services the Pediatric Enrollee receives may be less than the Non-Dentegra Provider's actual charges, the out-of-pocket cost may be significantly higher. We advise the Pediatric Enrollees of any charges not payable by us for which the Pediatric Enrollee is responsible. These charges are generally his/her share of the Maximum Contract Allowance, as well as any Deductibles and/or charges for non-covered services.

How to Submit a Claim

Dentegra does not require special Claim Forms. However, most dental offices have Claim Forms available. Dentegra Providers will fill out and submit the Pediatric Enrollee's claims paperwork. Some Non-Dentegra Providers may also provide this service upon request. If the Pediatric Enrollee receives services from a Non-Dentegra Provider who does not provide this service, the claim can be submitted directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

The Pediatric Enrollee's dental office should be able to assist him/her in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

CLAIMS APPEALS

We will notify the Pediatric Enrollee and his/her Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Pediatric Enrollee and his/her Provider have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why he/she believe the denial was wrong. The Pediatric Enrollee may also ask us to examine any additional information that may support the appeal or grievance.

Send appeal or grievance to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1809]

We will send the Pediatric Enrollee a written acknowledgment within five (5) days upon receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, we shall consult with a Dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. We will send the Pediatric Enrollee a decision within 30 days after receipt of the Pediatric Enrollee's appeal [or grievance].

If the Pediatric Enrollee believes further review is needed of their appeal [or grievance], he/she may contact the state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Pediatric Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Pediatric Enrollee has questions about the rights under ERISA. The Pediatric Enrollee may also bring a civil action under Section 502(a) of

ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GENERAL PROVISIONS

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to the Pediatric Enrollee as may be required to administer the claim, or have the Pediatric Enrollee examined by a dental consultant retained by us at our own expense, in or near his/her community or a residence. We will in every case hold such information and records confidential.

Notice of Claim Form

We will give the Pediatric Enrollee or his/her Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by us within 15 days after requested by the Pediatric Enrollee or his/her Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. The Pediatric Enrollee or his/her Provider may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss and must include information regarding other group coverage if applicable. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to us within 12 months of the termination of the Contract.

Time of Payment

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. We will notify the Pediatric Enrollee and his/her Provider of any additional information needed to process the claim within this 30 day period.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific Dentist. Payment for services provided by a Dentegra Provider will be made directly to the Dentist. Any other payments provided by the Contract will be made to the Pediatric Enrollee , unless he/she requests when filing a proof of claim that the payment be made directly to the dentist providing the services. All Benefits not paid to the Provider will be payable to the Pediatric Enrollee, or to his/her estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all statements made by the Employee or the Pediatric Enrollee or the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under the Contract, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement made with intent to deceive which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same Premium rate. If any misstatement would materially affect the

rates, we reserve the right to adjust the Premium to reflect the Pediatric Enrollee's actual circumstances at enrollment.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the Contract, nor will an action be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Conformity With Prevailing Laws

All legal questions about the Contract will be governed by the state of Tennessee where the Contract was entered into and is to be performed. Any part of the Contract which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

EMPLOYEE NOTICE

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
(2) the insurer was not authorized to do business in this state;
(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) any policy of reinsurance (unless an assumption certificate was issued);
(3) interest rate yields that exceed an average rate;
(4) dividends;
(5) credits given in connection with the administration of a policy by a group contract holder;
(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association 150 3rd Avenue South, Suite 1600 Nashville, TN 37201

Tennessee Department of Commerce and Insurance 500 James Robertson Parkway Nashville,Tennessee 37243

NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to tell you how Dentegra protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate. These affiliates have also implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.
  For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.
- Uses and/or disclosures of PHI for payment.
  For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.
- Uses and/or disclosures of PHI for health care operations.
  For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.

Disclosures Without an Authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Disclosures Dentegra Makes With Your Authorization

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

Your Rights Regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the Dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your Dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by email. You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

Contact

You may contact the Privacy Department at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Phone: [877-280-4204]

This notice is effective on and after August 1, 2012

Attachment A
Deductibles, Maximums and Contract Benefit Levels
Dentegra Dental PPO
Children's Plan 85

Deductibles & Maximums	
Annual Deductible	$25 per Pediatric Enrollee each Calendar Year The annual Deductible is waived for Diagnostic and Preventive Services.
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Pediatric Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers*	
Individual	$700 each Calendar Year
Multiple Child	$1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount a Pediatric Enrollee must satisfy for covered dental services under the Contract during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If an Employee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO Providers†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Medically Necessary Orthodontic Services (requires Prior Authorization)	50%	50%

†Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

Attachment A
Deductibles, Maximums and Contract Benefit Levels
Dentegra Dental PPO
Children's Plan 70

Deductibles & Maximums	
Annual Deductible	$45 per Pediatric Enrollee each Calendar Year
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Pediatric Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers*	
Individual	$700 each Calendar Year
Multiple Child	$1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount a Pediatric Enrollee must satisfy for covered dental services under the Contract during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If an Employee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO Providers†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	50%	50%
Major Services	50%	50%
Medically Necessary Orthodontic Services (requires Prior Authorization)	50%	50%

†Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

Attachment B
Services, Limitations and Exclusions
Dentegra Dental PPO
Children's Plan [85/70][D1]

Description of Dental Services

Dentegra will pay or otherwise discharge the Contract Benefit Level shown in Attachment A for the services shown on Attachment B-1 when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthdontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a Prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

Limitations

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Dentegra will pay for oral examinations (except exams for observation) no more than twice in a Calendar Year. Only one (1) comprehensive evaluation is allowed in a Calendar Year and counts toward the oral examination frequency in the year provided. One (1) limited oral evaluation, problem-focused no more than once in a Calendar Year.

(5) X-ray limitations:

a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(6) Dentegra will pay for routine cleanings and topical application of fluoride solutions no more than twice in a Calendar Year, and periodontal cleanings in the presence of inflamed gums up to four (4) times in a Calendar Year. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings not to exceed four (4) procedures or any combination thereof in a Calendar Year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

(7) Space maintainer limitations:

a) Space maintainers are limited to the initial appliance.
b) Recementation of space maintainer is limited to once per lifetime.

c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(8) Sealants are limited as follows:
a) to permanent molars through age 18 if they are without caries (decay) or restorations on the occlusal surface.
b) do not include repair or replacement of a Sealant on any tooth within 36 months of its application.

(9) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.

(10) Dentegra will not cover to replace an amalgam or resin-based composite within 24 months of treatment if the service is provided by the same Provider/Provider office. Pefabricated stainless steel crowns are limited to once per Enrollee per tooth per lifetime. Replacement restorations within 24 months are included in the fee for the original restoration.

(11) Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 15.

(12) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only. It is a benefit for primary incisor teeth up to age six (6) and for primary molars and cuspids to age 11.

(13) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(14) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Retrograde fillings per root are limited to once in any 24-month period.

(17) Pin retention is covered not more than once in any 24-month period.

(18) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(19) Period ontal limitations:
a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
b) Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
f) One crown lengthening per tooth per lifetime.

(20) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(21) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(22) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any 60 month period.

(23) Core buildup, including any pins, are covered not more than once in any 60 month period.

(24) Post and core services are covered not more than once in any 60 month year period.

(25) Crown repairs are covered not more than once in any 60 month period.

(26) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(27) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(28) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Removable cast base partial dentures are limited to Enrollees age 12 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.

(29) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(30) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a (6) month period by the same Provider/Provider office.

(31) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Contractholder's prior plan, if applicable

(32) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments and relining are limited to one (1) per arch in a 36-month period.
   c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
   d) Recementation of fixed partial dentures is limited to once in a lifetime.

(33) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period.

(34) Athletic mouth guards are limited to one (1) per 12 consecutive month period.

(35) Internal bleaching of discolored teeth shall not be provided for any tooth more than once each 36 months while the patient is an Enrollee under any Dentegra plan.

Exclusions

Dentegra does not pay Benefits for:

(1) services not included on Attachment B-1 Schedule of Covered Services except medically necessary Orthodontics provided a Prior Authorization is obtained.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) maxillofacial prosthetics.

(5) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).

(6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.

(8) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(10) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures if such procedures included in Attachment B-1.

(11) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(12) laboratory processed crowns for Enrollees under age 12.

(13) fixed bridges and removable partials for Enrollees under age 16.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) overdentures.

(16) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(17) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(18) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(19) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(20) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(21) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(22) Deductibles and/or any service not covered under the dental plan.

(23) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(24) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan with Dentegra or the Contractholder's prior dental plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(25) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(26) endodontic endosseous implant.

Attachment B-1
Schedule of Covered Services and Limitations

Please note the following:

• Dentegra will pay Benefits for dental services described in this attachment when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

• Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

• The codes and nomenclature in this Schedule are copyright of the American Dental Association. This table represents codes and nomenclature excerpted from the version of Current Dental Terminology (CDT)© in effect at the date of this printing. Dentegra's administration of benefits, limitations and exclusions under this plan at all times will be based on the current version of CDT whether or not a revised table is provided.

Category	Procedure Code	Procedure Description	Limitations
D&P	D0120	Periodic oral evaluation - established patient	2 in a calendar year
D&P	D0140	Limited oral evaluation - problem focused	1 in a calendar year
D&P	D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	
D&P	D0150	Comprehensive oral evaluation - new or established patient	1 in a calendar year
D&P	D0160	Detailed and extensive oral evaluation - problem focused, by report	problem focused, by report
D&P	D0180	Comprehensive periodontal evaluation - new or established patient	2 in a calendar year
D&P	D0210	Intraoral - complete series of radiographic images	Limited to 1 every 5 years
D&P	D0220	Intraoral - periapical first radiographic image	
D&P	D0230	Intraoral - periapical each additional radiographic image	
D&P	D0240	Intraoral - occlusal radiographic image	
D&P	D0250	Extraoral - first radiographic image	
D&P	D0260	Extraoral - each additional radiographic image	
D&P	D0270	Bitewing - single radiographic image	
D&P	D0272	Bitewings - two radiographic images	2 in a calendar year
D&P	D0273	Bitewings - three radiographic images	2 in a calendar year
D&P	D0274	Bitewings - four radiographic images	2 in a calendar year
D&P	D0277	Vertical bitewings - 7 to 8 radiographic images	
D&P	D0330	Panoramic radiographic image	

Category	Procedure Code	Procedure Description	Limitations
D&P	D0425	Caries susceptibility tests	
D&P	D1110	Prophylaxis - adult	2 in a calendar year
D&P	D1120	Prophylaxis - child	2 in a calendar year
D&P	D1206	Topical application of fluoride varnish	
D&P	D1208	Topical application of fluoride	2 in a calendar year
D&P	D1351	Sealant - per tooth	1 per tooth every 36 months
D&P	D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	
D&P	D1510	Space maintainer - fixed - unilateral	
D&P	D1515	Space maintainer - fixed - bilateral	
D&P	D1520	Space maintainer - removable - unilateral	
D&P	D1525	Space maintainer - removable - bilateral	
D&P	D1550	Re-cementation of space maintainer	
Basic	D2140	Amalgam - one surface, primary or permanent	1 every 24 month period
Basic	D2150	Amalgam - two surfaces, primary or permanent	1 every 24 month period
Basic	D2160	Amalgam - three surfaces, primary or permanent	1 every 24 month period
Basic	D2161	Amalgam - four or more surfaces, primary or permanent	1 every 24 month period
Basic	D2330	Resin-based composite - one surface, anterior	1 every 24 month period
Basic	D2331	Resin-based composite - two surfaces, anterior	1 every 24 month period
Basic	D2332	Resin-based composite - three surfaces, anterior	1 every 24 month period
Basic	D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	1 every 24 month period
Basic	D2391	Resin-based composite - one surface, posterior	1 every 24 month period
Basic	D2392	Resin-based composite - two surfaces, posterior	1 every 24 month period
Basic	D2393	Resin-based composite - three surfaces, posterior	1 every 24 month period
Basic	D2394	Resin-based composite - four or more surfaces, posterior	1 every 24 month period
Major	D2510	Inlay - metallic - one surface	
Major	D2520	Inlay - metallic - two surfaces	
Major	D2530	Inlay - metallic - three or more surfaces	
Major	D2542	Onlay - metallic-two surfaces	Limited to 1 every 5 years
Major	D2543	Onlay - metallic-three surfaces	Limited to 1 every 5 years
Major	D2544	Onlay - metallic-four or more surfaces	Limited to 1 every 5 years

Category	Procedure Code	Procedure Description	Limitations
Major	D2740	Crown - porcelain/ceramic substrate	
Major	D2750	Crown - porcelain fused to high noble metal	Limited to 1 every 5 years
Major	D2751	Crown - porcelain fused to predominantly base metal	Limited to 1 every 5 years
Major	D2752	Crown - porcelain fused to noble metal	Limited to 1 every 5 years
Major	D2780	Crown - 3/4 cast high noble metal	Limited to 1 every 5 years
Major	D2781	Crown - 3/4 cast predominantly base metal	Limited to 1 every 5 years
Major	D2782	Crown - 3/4 cast noble metal	Limited to 1 every 5 years
Major	D2783	Crown - 3/4 porcelain/ceramic	Limited to 1 every 5 years
Major	D2790	Crown - full cast high noble metal	Limited to 1 every 5 years
Major	D2791	Crown - full cast predominantly base metal	Limited to 1 every 5 years
Major	D2792	Crown - full cast noble metal	Limited to 1 every 5 years
Major	D2794	Crown - titanium	Limited to 1 every 5 years
Major	D2910	Recement inlay, onlay, or partial coverage restoration	Once per 6-month period
Major	D2920	Recement crown	Once per 6-month period
Basic	D2930	Prefabricated stainless steel crown - primary tooth	
Basic	D2931	Prefabricated stainless steel crown - permanent tooth	
Major	D2950	Core buildup, including any pins	Limited to 1 every 5 years
Major	D2951	Pin retention - per tooth, in addition to restoration	Limited to 1 every 24 months
Major	D2954	Prefabricated post and core in addition to crown	Limited to 1 every 5 years
Major	D2980	Crown repair necessitated by restorative material failure	
Major	D2981	Inlay repair necessitated by restorative material failure	
Major	D2982	Onlay repair necessitated by restorative material failure	
Major	D2983	Veneer repair necessitated by restorative material failure	
Basic	D2990	Resin infiltration of incipient smooth surface lesions	
Major	D3110	Pulp cap - direct (excluding final restoration)	
Major	D3120	Pulp cap - indirect (excluding final restoration)	
Major	D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	
Major	D3221	Pulpal debridement, primary and permanent teeth	

Category	Procedure Code	Procedure Description	Limitations
Major	D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	
Major	D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	
Major	D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	
Major	D3310	Endodontic therapy, anterior tooth (excluding final restoration)	
Major	D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	
Major	D3330	Endodontic therapy, molar (excluding final restoration)	
Major	D3346	Retreatment of previous root canal therapy - anterior	
Major	D3347	Retreatment of previous root canal therapy - bicuspid	
Major	D3348	Retreatment of previous root canal therapy - molar	
Major	D3351	Apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	
Major	D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	
Major	D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
Major	D3354	Pulpal regeneration - (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	
Major	D3410	Apicoectomy/periradicular surgery - anterior	
Major	D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
Major	D3425	Apicoectomy/periradicular surgery - molar (first root)	
Major	D3426	Apicoectomy/periradicular surgery (each additional root)	
Major	D3430	Retrograde filling - per root	
Major	D3450	Root amputation - per root	
Major	D3920	Hemisection (including any root removal), not including root canal therapy	

Category	Procedure Code	Procedure Description	Limitations
Major	D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Limited to 1 every 24 months
Major	D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4249	Clinical crown lengthening - hard tissue	
Major	D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4268	Surgical revision procedure, per tooth	
Major	D4270	Pedicle soft tissue graft procedure	
Major	D4273	Subepithelial connective tissue graft procedures, per tooth	
Major	D4275	Soft tissue allograft	
Major	D4276	Combined connective tissue and double pedicle graft, per tooth	
Major	D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	
Major	D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	
Major	D4341	Periodontal scaling and root planing - four or more teeth per quadrant	Limited to 1 every 24 months
Major	D4342	Periodontal scaling and root planing - one to three teeth per quadrant	Limited to 1 every 24 months
Basic	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Limited to 1 per lifetime
Major	D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	
Basic	D4910	Periodontal maintenance	Up to 4 periodontal maintenance procedures and up to 2 routine cleanings not to exceed 4
Major	D5110	Complete denture - maxillary	Limited to 1 every 5 years
Major	D5120	Complete denture - mandibular	Limited to 1 every 5 years
Major	D5130	Immediate denture - maxillary	Limited to 1 every 5 years

Category	Procedure Code	Procedure Description	Limitations
Major	D5140	Immediate denture - mandibular	Limited to 1 every 5 years
Major	D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years
Major	D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years
Major	D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years
Major	D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years
Major	D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	Limited to 1 every 5 years
Major	D5410	Adjust complete denture - maxillary	
Major	D5411	Adjust complete denture - mandibular	
Major	D5421	Adjust partial denture - maxillary	
Major	D5422	Adjust partial denture - mandibular	
Major	D5510	Repair broken complete denture base	
Major	D5520	Replace missing or broken teeth - complete denture (each tooth)	
Major	D5610	Repair resin denture base	
Major	D5620	Repair cast framework	
Major	D5630	Repair or replace broken clasp	
Major	D5640	Replace broken teeth - per tooth	
Major	D5650	Add tooth to existing partial denture	
Major	D5660	Add clasp to existing partial denture	
Major	D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	
Major	D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	
Major	D5710	Rebase complete maxillary denture	Limited to 1 in a 36-months
Major	D5711	Rebase complete mandibular denture	Limited to 1 in a 36-months
Major	D5720	Rebase maxillary partial denture	Limited to 1 in a 36-months
Major	D5721	Rebase mandibular partial denture	Limited to 1 in a 36-months
Major	D5730	Reline complete maxillary denture (chairside)	Limited to 1 in a 36-months
Major	D5731	Reline complete mandibular denture (chairside)	Limited to 1 in a 36-months
Major	D5740	Reline maxillary partial denture (chairside)	Limited to 1 in a 36-months
Major	D5741	Reline mandibular partial denture (chairside)	Limited to 1 in a 36-months

Category	Procedure Code	Procedure Description	Limitations
Major	D5750	Reline complete maxillary denture (laboratory)	Limited to 1 in a 36-months
Major	D5751	Reline complete mandibular denture (laboratory)	Limited to 1 in a 36-months
Major	D5760	Reline maxillary partial denture (laboratory)	Limited to 1 in a 36-months
Major	D5761	Reline mandibular partial denture (laboratory)	Limited to 1 in a 36-months
Major	D5850	Tissue conditioning, maxillary	
Major	D5851	Tissue conditioning, mandibular	
Major	D6010	Surgical placement of implant body: endosteal implant	Limited to 1 every 5 years
Major	D6053	Implant/abutment supported removable denture for completely edentulous arch	Limited to 1 every 5 years
Major	D6054	Implant/abutment supported removable denture for partially edentulous arch	Limited to 1 every 5 years
Major	D6055	Connecting bar - implant supported or abutment supported	Limited to 1 every 5 years
Major	D6056	Prefabricated abutment - includes modification and placement	Limited to 1 every 5 years
Major	D6057	Custom fabricated abutment - includes placement	Limited to 1 every 5 years
Major	D6058	Abutment supported porcelain/ceramic crown	Limited to 1 every 5 years
Major	D6059	Abutment supported porcelain fused to metal crown (high noble metal)	Limited to 1 every 5 years
Major	D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Limited to 1 every 5 years
Major	D6061	Abutment supported porcelain fused to metal crown (noble metal)	Limited to 1 every 5 years
Major	D6062	Abutment supported cast metal crown (high noble metal)	Limited to 1 every 5 years
Major	D6063	Abutment supported cast metal crown (predominantly base metal)	Limited to 1 every 5 years
Major	D6064	Abutment supported cast metal crown (noble metal)	Limited to 1 every 5 years
Major	D6065	Implant supported porcelain/ceramic crown	Limited to 1 every 5 years
Major	D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	Limited to 1 every 5 years
Major	D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	Limited to 1 every 5 years
Major	D6068	Abutment supported retainer for porcelain/ceramic FPD	Limited to 1 every 5 years
Major	D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	Limited to 1 every 5 years
Major	D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	Limited to 1 every 5 years

Category	Procedure Code	Procedure Description	Limitations
Major	D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	Limited to 1 every 5 years
Major	D6072	Abutment supported retainer for cast metal FPD (high noble metal)	Limited to 1 every 5 years
Major	D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	Limited to 1 every 5 years
Major	D6074	Abutment supported retainer for cast metal FPD (noble metal)	Limited to 1 every 5 years
Major	D6075	Implant supported retainer for ceramic FPD	Limited to 1 every 5 years
Major	D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	Limited to 1 every 5 years
Major	D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	Limited to 1 every 5 years
Major	D6078	Implant/abutment supported fixed denture for completely edentulous arch	Limited to 1 every 5 years
Major	D6079	Implant/abutment supported fixed denture for partially edentulous arch	Limited to 1 every 5 years
Major	D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	Limited to 1 every 5 years
Major	D6090	Repair implant supported prosthesis, by report	Limited to 1 every 5 years
Major	D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	Limited to 1 every 5 years
Major	D6094	Abutment supported crown - (titanium)	Limited to 1 every 5 years
Major	D6095	Repair implant abutment, by report	Limited to 1 every 5 years
Major	D6100	Implant removal, by report	Limited to 1 every 5 years
Major	D6194	Abutment supported retainer crown for FPD - (titanium)	Limited to 1 every 5 years
Major	D6210	Pontic - cast high noble metal	Limited to 1 every 5 years
Major	D6211	Pontic - cast predominantly base metal	Limited to 1 every 5 years
Major	D6212	Pontic - cast noble metal	Limited to 1 every 5 years
Major	D6214	Pontic - titanium	Limited to 1 every 5 years
Major	D6240	Pontic - porcelain fused to high noble metal	Limited to 1 every 5 years
Major	D6241	Pontic - porcelain fused to predominantly base metal	Limited to 1 every 5 years
Major	D6242	Pontic - porcelain fused to noble metal	Limited to 1 every 5 years
Major	D6245	Pontic - porcelain/ceramic	Limited to 1 every 5 years
Major	D6545	Retainer - cast metal for resin bonded fixed prosthesis	Limited to 1 every 5 years

Category	Procedure Code	Procedure Description	Limitations
Major	D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Limited to 1 every 5 years
Major	D6601	Inlay - porcelain/ceramic, three or more surfaces	Limited to 1 every 5 years
Major	D6604	Inlay - cast predominantly base metal, two surfaces	Limited to 1 every 5 years
Major	D6605	Inlay - cast predominantly base metal, three or more surfaces	Limited to 1 every 5 years
Major	D6613	Onlay - cast predominantly base metal, three or more surfaces	Limited to 1 every 5 years
Major	D6740	Crown - porcelain/ceramic	Limited to 1 every 5 years
Major	D6750	Crown - porcelain fused to high noble metal	Limited to 1 every 5 years
Major	D6751	Crown - porcelain fused to predominantly base metal	Limited to 1 every 5 years
Major	D6752	Crown - porcelain fused to noble metal	Limited to 1 every 5 years
Major	D6780	Crown - 3/4 cast high noble metal	Limited to 1 every 5 years
Major	D6781	Crown - 3/4 cast predominantly based metal	Limited to 1 every 5 years
Major	D6782	Crown - 3/4 cast noble metal	Limited to 1 every 5 years
Major	D6783	Crown - 3/4 porcelain/ceramic	Limited to 1 every 5 years
Major	D6790	Crown - full cast high noble metal	Limited to 1 every 5 years
Major	D6791	Crown - full cast predominantly base metal	Limited to 1 every 5 years
Major	D6792	Crown - full cast noble metal	Limited to 1 every 5 years
Major	D6794	Crown - titanium	Limited to 1 every 5 years
Major	D6930	Recement fixed partial denture	
Major	D6980	Fixed partial denture repair necessitated by restorative material failure	
Major	D7111	Extraction, coronal remnants - deciduous tooth	
Major	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
Major	D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	
Major	D7220	Removal of impacted tooth - soft tissue	
Major	D7230	Removal of impacted tooth - partially bony	
Major	D7240	Removal of impacted tooth - completely bony	
Major	D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
Major	D7250	Surgical removal of residual tooth roots (cutting procedure)	
Major	D7251	Coronectomy - intentional partial tooth removal	

Category	Procedure Code	Procedure Description	Limitations
Major	D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
Major	D7280	Surgical access of an unerupted tooth	
Major	D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	
Major	D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
Major	D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	
Major	D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
Major	D7471	Removal of lateral exostosis (maxilla or mandible)	
Major	D7510	Incision and drainage of abscess - intraoral soft tissue	
Major	D7910	Suture of recent small wounds up to 5 cm	
Major	D7921	Collection and application of autologous blood concentrate product	
Major	D7971	Excision of pericoronal gingiva	
Major	D7999	Unspecified oral surgery procedure, by report	
Basic	D9110	Palliative (emergency) treatment of dental pain - minor procedure	
Basic	D9220	Deep sedation/general anesthesia - first 30 minutes	
Basic	D9221	Deep sedation/general anesthesia - each additional 15 minutes	
Basic	D9241	Intravenous conscious sedation/analgesia - first 30 minutes	
Basic	D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
D&P	D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	1 per lifetime
Basic	D9440	Office visit - after regularly scheduled hours	
Basic	D9610	Therapeutic parenteral drug, single administration	
Basic	D9612	Therapeutic parenteral drugs, two or more administrations, different medications	
Basic	D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	
Major	D9940	Occlusal guard, by report	1 in 12 months for patients 13 and older

Category	Procedure Code	Procedure Description	Limitations
Major	D9941	Fabrication of athletic mouthguard	
Major	D9974	Internal bleaching - per tooth	
Major	D9999	Unspecified adjunctive procedure, by report	

ATTACHMENT C
GROUP VARIABLES
[Information in this section is variable.]
for
[Contractholder[D1] Name]
[Group Number]

Effective Date:

Contract Term:

Premiums:
Monthly Amount:

[Pediatric[D2] Enrollee]	$ [XX[D3]]

Premiums are to be remitted to:

Dentegra Insurance Company
[[SF4]P.O. Box 1850
Alpharetta, GA 30023-1850]

Payment Breakdown:

Contractholder shall pay:	[XX[D5]]	%	for Pediatric Enrollees
Contractholder's employee shall pay:	[XX[D6]]	%	for Pediatric Enrollees

Contractholder may charge persons electing continued coverage pursuant to Title X of P.L. 99 as permitted by law.

DENTEGRA® INSURANCE COMPANY
[1130[D1] Sanctuary Parkway
Suite 600
Alpharetta, Georgia 30009
(877) 280-4204]

Group Dental PPO Insurance Contract

The Contractholder named in Attachment E Group Variables ("Attachment E") applied for a group dental insurance Contract with Dentegra Insurance Company ("Dentegra") [through[DS2] the Packaged Offering with the Medical Plan Issuer ("MPI"), [insert Medical Plan Issuer name]]. This Contract is underwritten by Dentegra Insurance Company ("Dentegra") and administered by Delta Dental Insurance Company. The following terms will apply:

I. [Contractholder[DS3] will pay the MPI or its third party administrator the monthly Premium stated in this Contract.]
[Contractholder[DS4] will pay Dentegra or its Third Party Administrator the monthly Premium stated in this Contract.]

II. When the Contractholder pays the first month's Premium, the term of this Contract will begin at 12:01 a.m. Standard Time, on the Effective Date listed in Attachment E. The term of this Contract will end as stated in this Contract at the end of the Contract Term at 12:00 midnight Standard Time.

III. [Contractholder will[CR5] provide each Employee with electronic access to a certificate/Evidence of Coverage booklet supplied by [Dentegra[DS6]/the MPI]. [Dentegra[DS7]/The MPI] will also furnish a hard copy to the Enrollee or Contractholder upon request]. [Contractholder[D8] will provide each Employee a certificate/Evidence of Coverage booklet supplied by [Dentegra[DS9]/the MPI]. Contractholder will also distribute to its Employees any notice from [Dentegra[DS10]/the MPI] which may affect their child's rights under this Contract.

So long as Contractholder pays the Premiums stated in Article 3, Dentegra agrees to provide the Benefits described in this Contract including Attachment A Deductibles, Maximums and Contract Benefit Levels ("Attachment A"); Attachment B Services, Limitations and Exclusions ("Attachment B"); Attachment B-1 Schedule of Covered Services and Limitations for Pediatric Benefits ("Attachment B-1"); Attachment C Deductibles, Maximums and Contract Benefit Levels For Adult Benefits ("Attachment C") and Attachment D Services, Limitations and Exclusions For Adult Benefits ("Attachment D").

Anthony S. Barth, Vice Chairman

Essential Health Benefit Plan – The Essential Health Benefit Plan ("Pediatric Benefits") provides coverage to Eligible Pediatric Enrollees who are dependent children of employees to whom Contractholder offers coverage. Such children are eligible for Benefits under this Contract from birth to age 19. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulation and as may be recognized by the Contractholder.

Supplemental Adult Group Benefit Plan – The Adult Group Benefit Plan provides coverage for Eligible Employees and/or Eligible Dependents which include the Eligible Employee's Spouse and children to age 26. [Additionally, [D11]children from birth to age 19 are covered for services not covered under Pediatric Benefits]. Dependent children of the Eligible Employee include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulations and as may be recognized by the Contractholder.

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ARTICLE 1
DEFINITIONS

Terms when capitalized in this document have defined meanings, given either in the section below or within the Contract sections.

1.01 **Accepted Fee --** the amount the attending Provider agrees to accept as payment in full for services rendered.

1.02 **Benefits** -- the amounts that Dentegra will pay for dental services under this Contract.

1.03 **Calendar Year** -- the 12 months of the year from January 1 through December 31.

1.04 **Claim Form** -- the standard form used to file a claim, request a Pre-Treatment Estimate or request Prior Authorization for medically necessary orthodontics.

1.05 **Contract** -- this agreement between Dentegra and Contractholder, including the attachments listed in Article 12.

1.06 **Contractholder –** a small group employer named in Attachment E.

1.07 **Contract Term** -- the period during which this Contract is in effect, as shown in Attachment E.

1.08 **Contract Year** – the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

1.09 **Dentegra PPO℠ Provider (Dentegra Provider)** -- a Provider who contracts with Dentegra and agrees to accept Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO dental plan.

1.10 **Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee)** -- the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Enrollees.

1.11 **Effective Date** -- the original date this Contract starts, as shown in Attachment E.

1.12 **Maximum Contract Allowance --** the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided.

- by Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee;
- by Non-Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic area.

1.13 [**Medical**[DS12] **Plan Issuer (MPI)** – the entity providing the medical plan that is issued and delivered to Contractholder with this dental plan as a Packaged Offering.]

1.14 **Non-Dentegra Provider --** a Provider who is not a Dentegra Provider and has not agreed to accept the Dentegra Provider's Contracted Fees.

1.15 **Open Enrollment Period** – the period of the year the [employer[DS13]/MPI] has established during which employees may change coverage selections for the next Contract Year.

1.16 [**Packaged**[DS14] **Offering** – the selection of a separate medical plan provided by the MPI bundled with this dental plan provided by Dentegra.]

1.17 **Premium** -- the amounts payable by the Contractholder monthly as provided in Attachment E.

1.18 **Pre-Treatment Estimate** -- an estimation of the allowable Benefits under this Contract for the services proposed, assuming the person is an eligible Enrollee.

1.19 **Procedure Code** – the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

1.20 **Program Allowance** -- the amount determined for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

1.21 **Provider** -- a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

1.22 **Qualifying Status Change** -- a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);

- employment status (change in employment status of employee);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee, dependent spouse or child moves);
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125

1.23 **Single Procedure** -- a dental procedure that is assigned a separate Procedure Code.

1.24 **Submitted Fee** -- the amount that the Provider bills and enters on a claim for a specific procedure.

ARTICLE 2
CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

2.01 Dentegra will pay Benefits for dental services described in Attachments B and D when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and exclusions will be applied for the period the person enrolled under any Dentegra program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional waiting periods, if any, are shown in Attachments A and C.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

2.02 Dentegra's provision of Benefits is limited to the applicable portion of the Provider's fees or allowances specified in Attachments A and C for Diagnostic and Preventive, Basic, Major, and Medically Necessary Orthodontic Services. The Enrollee is responsible for paying the balance of any fees or allowances known as "Coinsurance". Contractholder has chosen to require Coinsurances under this program as a method of sharing the costs of providing dental Benefits between Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Coinsurance to the Enrollee, Dentegra will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of such Coinsurance fees or allowances that are discounted, waived or rebated.

2.03 **Deductible**
Dentegra will not pay Benefits for services received each Calendar Year by an Enrollee until the Deductible, as shown in Attachments A and C, has been satisfied. The annual Deductible per family, if any, is shown in Attachments A and C. Only fees an Enrollee pays for covered services will count toward the Deductible.

2.04 **Maximum**.
A maximum amount ("Maximum Amount" or "Maximum") is the maximum dollar amount Dentegra will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. Dentegra will pay the Maximum Amount(s), if applicable, shown in Attachments A and C for Benefits under this Contract.

2.05 **Coordination of Benefits**
Dentegra coordinates the Benefits under this Contract with an Enrollee's benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. If this Contract is the "primary" plan, Dentegra will not reduce Benefits. If this is the "secondary" plan, Dentegra may reduce Benefits otherwise payable under this Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

Order of Benefit Determination Rules:
The following rules determine which plan is the "primary" plan:
(1) The plan covering the Enrollee as an employee is primary over a plan covering the Enrollee as a dependent.
(2) The plan covering the Enrollee as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    a) Secondary to the plan covering the insured person as a dependent and
    b) Primary to the plan covering the insured person as other than a dependent (e.g. a retired employee),
    then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
(3) Except as stated in paragraph (4), when this plan and another plan cover the same child as a dependent of different persons, called parents:
    a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but

b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

(5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).

(6) The benefits of a plan which covers an insured person as an employee who is neither laid-off nor retired are determined before those of a plan which covers that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (6) is ignored.

(7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
a) First, the benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
b) Second, the benefits under the continuation coverage.
If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(8) If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the plan which covered that insured person for the shorter term.

(9) When determination cannot be made in accordance with the above for Pediatric Benefits, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

2.06 **Clinical Examination**

Before approving a claim, Dentegra may obtain, to such extent as may be lawful, from any Provider, or from hospitals in which a Provider's care is provided, such information and records relating to an Enrollee as Dentegra may require to administer the claim. Dentegra, at its own expense, may also require that an Enrollee be examined by a dental consultant retained by Dentegra, as often as necessary, in or near his/her community or residence while a claim is pending. Such information and records will be kept confidential in accordance with all applicable laws and regulations.

2.07 **Notice of Claim Forms**

Dentegra will furnish to any Provider or Enrollee, on request, a Claim Form to make a claim for payment of Benefits. To make a claim, the Claim Form must be completed and signed by the Provider who performed the services and by the Enrollee (or the parent or guardian of a minor) and submitted to Dentegra at the address shown thereon. If Dentegra does not furnish the form within 15 days after requested by a Provider or Enrollee, the requirements for proof of loss set forth in section 2.09 of this Contract will be deemed to have been complied with upon the submission to Dentegra within the time established in said section for filing proof of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. Enrollees may download a Claim Form from Dentegra's website.

2.08 **Prior Authorization for Medically Necessary Orthodontics**

Orthodontic treatment is covered under Pediatric Benefits, which are shown in Attachments A, B and B-1, only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

2.09 **Pre-Treatment Estimates**

A Provider may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Dentegra will estimate the amount of Benefits payable under this Contract for the listed services. Benefits will be processed according to the terms of this Contract when the treatment is performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date this Contract terminates;
- the date Benefits under this Contract are amended if services in the Pre-Treatment Estimate are part of the amendment;
- the date the Enrollee's coverage ends; or
- the date the Provider's agreement with Dentegra ends.

2.10 **Written Notice of Claim/Proof of Loss**

Dentegra must be given a written notice of claim, sometimes referred to as a written proof of loss, within 12 months after the date of the loss and must include information regarding other group coverage if applicable. If it is not

reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one (1) year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Dentegra within 12 months of the termination of this Contract.

2.11 **Time of Payment**
Claims payable under this Contract for any loss other than for which this Contract provides any periodic payment will be paid no later than 30 days after written proof of loss is received. Dentegra will notify the Primary Enrollee and his/her Provider of any additional information needed to process the claim within this 30 day period.

2.12 **Claims Appeal**
Dentegra will notify the Enrollee and his/her Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Enrollee has at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to Dentegra giving reasons why they believe the denial was wrong. The Enrollee and his/her Provider may also ask Dentegra to examine any additional information provided that may support the appeal or grievance.

Send appeal or grievance to Dentegra at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Dentegra will send the Enrollee a written acknowledgment within five (5) days upon receipt of the appeal or grievance. Dentegra will make a full and fair review within 30 days after Dentegra receives the complaint, grievance or appeal. Dentegra may ask for more documents if needed. Dentegra will send the Enrollee a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Contract, Dentegra shall consult with a Dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. Dentegra will send Enrollee a decision within 30 days after receipt of the Enrollee's appeal [or grievance].

If the Enrollee believes he/she needs further review of their appeal or grievance, he/she may contact his/her state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action under Section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

2.13 **To Whom Benefits Are Paid**
Payment for services provided by a Dentegra Provider will be made directly to the Provider. Any other payments provided by this Contract will be made to the Primary Enrollee unless Enrollee requests when filing proof of loss that the payment be made directly to the Provider providing the services. All Benefits not paid to the Provider will be payable to the Primary Enrollee, to his/her estate, or to an alternate recipient as directed by court order except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

2.14 No change in Benefits will become effective during a Contract Term unless Contractholder and Dentegra agree in writing.

ARTICLE 3
REPORTING AND MONTHLY PREMIUMS

3.01 **Reporting**
Dentegra processes eligibility as reported by the [Contractholder[DS15]/MPI].

Contractholder is responsible for notifying [Dentegra[DS16]/the MPI] with additions, changes or terminations made during the prior month as required by [Dentegra[DS17]/the MPI]. An Enrollee remains enrolled until the Contractholder notifies [Dentegra[DS18]/the MPI] of the termination. If the Enrollee loses coverage or makes any change that affects eligibility, Contractholder must promptly notify [Dentegra[DS19]/the MPI] of such change.

Dentegra will not make any payment for services provided to an Enrollee who is not reported to Dentegra as eligible under this Contract when the service is provided. Also, Dentegra may not pay Benefits for an Enrollee if Premiums are not paid for the month in which dental services are rendered. Dentegra shall not be obligated to recover claims paid to a Provider as a result of Contractholder's retroactive eligibility adjustments. The Contractholder agrees to reimburse

Dentegra for any erroneous claim payments made by Dentegra as a result of incorrect eligibility reporting by the Contractholder to [Dentegra[DS20]/the MPI].

Retroactive[DS21] premium adjustments are limited to the immediately preceding three (3) months plus the current billing month.

3.02 Contractholder will permit Dentegra to audit Contractholder's records to confirm compliance with Article 3, 7 and 10. Dentegra will give Contractholder written notice within a reasonable time before the audit date.

3.03 [Contractholder [D22]will remit to the MPI or its third party administrator the Premium in the amount and manner shown in Attachment E for all Enrollees.] [Contractholder [D23]will remit to Dentegra or its Third Party Administrator the Premium in the amount and manner shown in Attachment E for all Enrollees.]

For[DS24] enrollment additions, Contractholder will remit a full month's Premium for Enrollees whose coverage is effective on the first through the fifteenth calendar day of a month. Premiums are not due to Dentegra for Enrollees who are enrolled on the sixteenth through the last day of a month.]

For[DS25] enrollment terminations, Contractholder will remit a full month's Premium for Enrollees whose coverage is terminated on the sixteenth through the last calendar day of a respective month. Premiums are not due to Dentegra for Enrollees whose enrollment is terminated on the first through the fifteenth day of a month.]

3.04 This Contract will not be in effect until Dentegra receives the first month's Premiums. Subsequent Premiums will be paid by the first day of each month. For each Premium after the first, a grace period of 31 days from the due date will be allowed for the payment of the Premium. This Contract will continue in force during this period; if the Premium remains unpaid at the end of the grace period, this Contract may be terminated by Dentegra in accordance with the notice requirements of section 4.01. Any payment received after 90 days of the due date shall be subject to interest charges at an annualized rate equal to one percentage point above the then current three (3) month U.S. Treasury Bill rate, which interest shall commence accruing as of the first day following the end of the 31 day grace period.

3.05 If this Contract is terminated before the end of a Contract Term, Contractholder will pay additional charges in accordance with Article 4.

3.06 Dentegra will not be responsible or liable for any incorrect, incomplete, obsolete or unreadable data or information supplied to Dentegra including, but not limited to, eligibility and enrollment information.

3.07 Dentegra may change the monthly Premium whenever this Contract is amended as stated in section 3.08, or whenever the Contractholder requests a change in Benefits, eligibility or when due to a state and/or federal mandated change. Any change in Premium shall not be effective during a Contract Term unless Contractholder and Dentegra agree in writing, except as provided in section 3.08 or a state and/or federal mandated change.

3.08 If during the Contract Term any new or increased tax, assessment, or fee is imposed on the amounts payable to, or by, Dentegra under this Contract or any immediately preceding contract between Dentegra and Contractholder, the Premium amount stated in Attachment E will be increased by the amount of any such new or increased tax, assessment, or fee by written notice to Contractholder, and this Contract shall thereby be modified on the date set forth in the notice.

ARTICLE 4
TERMINATION AND RENEWAL

4.01 This Contract may be terminated only as follows:

- By Dentegra upon 31 days written notice if Contractholder fails to pay Premiums, in the amount and manner required by Article 3.
- By Contractholder or Dentegra at the end of a Contract Term upon 60 days written notice.
- [By[DS26] Dentegra as of the termination date of the bundled medical plan as notified by the MPI.]

4.02 In the event this Contract is terminated under section 4.01 first bullet item, Contractholder will become immediately obligated upon termination to pay Dentegra for that portion of the monthly Premium which constitutes for the current Contract Term Dentegra's direct costs of administering this Contract (calculated by subtracting the pure Premium from the total Premium) multiplied by the remaining number of months from the date of termination to the expiration of the current Contract Term, but the amount will not exceed 25 percent of the total Premium for the entire Contract Term.

4.03 If Dentegra is notified that the Contractholder intends to terminate this Contract upon less than 60 days notice, Section 4.02 will apply as if Dentegra terminated this Contract under section 4.01 first bullet.

4.04 Dentegra will not be required to do Pre-Treatment Estimates if this Contract is terminated for any cause nor will Dentegra be required to pay for services performed beyond the termination date except for completion of Single Procedures commenced while this Contract was in effect as stated in section 7.04 and 10.05.

4.05 [Contractholder[DS27] will receive renewal information from the MPI prior to any applicable Open Enrollment Period. Provided Dentegra continues to make this policy available through the MPI at the renewal period, Contractholder may elect to continue to offer this Contract to Eligible Enrollees, subject to the applicable Premium available through the MPI for this plan at the time of renewal.]

[Dentegra[DS28] will provide [60][d29] days advance written renewal notice prior to the end of the initial or any subsequent Contract Terms indicating if Premiums and/or Benefits will remain the same or change. The Contractholder's payment of the Premium indicated in the renewal notice for the new Contract Term will signify the Contractholder's acceptance of the renewal. If the Contractholder fails to provide written notification to Dentegra of non-renewal by the date indicated in the renewal letter and/or does not pay the Premiums indicated in the renewal notice with the new Contract Term, Dentegra will terminate this Contract under section 4.01 first bullet.]

ARTICLE 5
GENERAL PROVISIONS

5.01 **Entire Contract: Changes**
This Contract, including the attachments listed in Article 12, is the entire agreement between the parties. No agent has authority to change this Contract or waive any of its provisions. No change in this Contract will be valid unless approved by an executive officer of Dentegra.

5.02 **Severability**
If any part of this Contract or an amendment of it is found by a court or other authority to be illegal, void or not enforceable, all other portions of this Contract will remain in full force and effect.

5.03 **Conformity With State Laws**
All legal questions about this Contract will be governed by the state of Tennessee where this Contract was entered into and is to be performed. Any part of this Contract which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

5.04 **Misstatements on Application; Effect**
In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of this Contract, all statements made by the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Contract, unless it is contained in a written instrument signed by the Contractholder, a copy of which has been furnished to such Contractholder.

5.05 **Legal Actions**
No action at law or in equity will be brought to recover on this Contract before 60 days after written proof of loss has been furnished in accordance with requirements of this Contract; nor will an action be brought after the expiration of three (3) years after the time written proof is required to be furnished.

5.06 **Not in Lieu of Workers' Compensation**
This Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

5.07 **Certificate of Insurance**
[[Dentegra[CR30]/MPI] will issue to the Contractholder an electronic file containing a certificate/EOC summarizing the Benefits to which Enrollees are entitled and to whom Benefits are payable. Each Eligible Employee enrolled under this Contract will have electronic access to the certificate.[[Dentegra[DS31]/The MPI] will also furnish a hard copy to an Enrollee or the Contractholder upon request]. [[Dentegra[D32]/The MPI] will issue to the Contractholder for delivery to each Eligible Employee enrolled under this Contract a certificate/EOC booklet summarizing the Benefits to which they are entitled and to whom Benefits are payable]. The certificate is not assignable and the Benefits are not assignable prior to a claim. If any amendment to this Contract will materially affect any Benefits described in the certificate, new certificates or amendments showing the change will be issued.

5.08 **Publications About Program**
Contractholder and Dentegra agree to consult as is reasonably practical on all material published or distributed about this Contract. No material will be published or distributed which conflicts with the terms of this Contract.

5.09 **Provider Relationship**
Contractholder and Dentegra agree to permit and encourage the professional relationship between Provider and Enrollee to be maintained without interference. Any Dentegra or Non-Dentegra Provider, including any Provider or employee associated with or employed by them, who provides dental services to Enrollees does so as an independent contractor and shall be solely responsible for dental advise and for performance of dental services, or lack thereof, to the Enrollee.

5.10 **Notice; Where Directed**
All formal notice under this Contract must be in writing and sent by email, facsimile (fax), first-class United States mail, overnight delivery service, or personal delivery. Notice by United States mail will be effective 48 hours after mailing with fully prepaid postage.

Contractholder shall designate in writing a representative for purposes of receiving notices from Dentegra under this Contract. Contractholder may change its representative at any time with 30 days written notice to Dentegra. The Contractholder's representative shall disseminate notices to the Enrollees within 30 days of receipt.

5.11 **Indemnification**

Contractholder will indemnify, defend and hold harmless Dentegra, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Contractholder's negligent performance or non-performance of its obligations under this Agreement.

Dentegra will indemnify, defend and hold harmless Contractholder and its employees and agents, against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Dentegra's negligent performance or non-performance of its obligations under this Agreement.

5.12 **Time Limit On Certain Defenses**

After this Contract has been in force for three (3) years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an Enrollee with respect to the Enrollee's insurability, will be used to reduce or deny a claim or contest the validity of insurance for such Enrollee after that person's coverage has been in effect three (3) years or more during his or her lifetime.

5.13 **Compliance with Administrative Simplification, Security and Privacy Regulations**

Contractholder and Dentegra shall comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable Enrollee information including executing a Business Associate Addendum as required by Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Contractholder and Dentegra agree that this Contract shall incorporate terms as necessary and as applicable to execute the required agreements (i.e. business associate agreement) to comply with federal regulations issued under the HIPAA, HITECH Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

5.14 **Impossibility of Performance**

Neither party shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires, or unusually severe weather. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

5.15 **Third Party Administrator ("TPA")**

Dentegra may use the services of a TPA, duly registered under applicable state law, to provide services under this Contract. Any TPA providing such services or receiving such information shall enter into a separate Business Associate Agreement with Dentegra providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

5.16 **Mutual Confidentiality**

Contractholder and Dentegra agree to maintain confidential information using the same degree of care (which shall be no less than reasonable care) as each uses to protect its own confidential information of a similar nature and to use confidential information only for specified purposes. Confidential information includes any information which the owner deems confidential, whether marked as confidential or otherwise clearly identifiable as confidential and includes information not generally known by the public or by parties which are competitive with or otherwise in an industry, trade or business similar to the owner of the confidential information. The recipient of confidential information shall notify the owner of any unauthorized disclosure or breach of confidentiality as soon as possible after discovery and without unreasonable delay.

5.17 **Trademarks; Service Marks**

Unless specifically allowed in this Contract, neither party shall use the name, trademarks, service marks or other proprietary branding of the other party without the advance written approval of the other party.

ARTICLE 6
ADDITIONAL DEFINITIONS FOR PEDIATRIC BENEFITS

Terms when capitalized in this document have defined meanings, given either in the section below or within the Contract sections.

6.01 **Contract Benefit Level** -- the percentage of the Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment A.

6.02 **Deductible** -- a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits as shown in Attachment A.

6.03 **Eligible Pediatric Enrollee** – a person eligible for Benefits under Article 7.

6.04 **Employee** – an individual employed by the Contractholder and who has opted to cover his/her child(ren) under this Contract.

6.05 **Out-of-Pocket Maximum** – the maximum amount a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from a Non-Dentegra Provider even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

6.06 **Patient Pays** – the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

6.07 **Pediatric Enrollee** – an Eligible Pediatric Enrollee enrolled to receive Benefits; may also be referred to as "Enrollee".

6.08 **Pediatric Enrollee's Effective Date of Coverage** – the date the [Contractholder[DS33]/MPI] reports coverage will begin for each Pediatric Enrollee.

ARTICLE 7
ELIGIBILITY AND ENROLLMENT FOR PEDIATRIC BENEFITS

7.01 **Eligible Pediatric Enrollee**
Eligible Pediatric Enrollees are dependent children of Employees to whom Contractholder offers coverage. Such dependent children are eligible for Benefits under this Contract from birth to age 26.

Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulations and as may be recognized by the Contractholder.

Pediatric Enrollees on active military duty are not eligible.

7.02 **Enrollment of Eligible Pediatric Enrollees**
The [Contractholder[DS34]/MPI] is responsible for establishing the Pediatric Enrollee's Effective Date of Coverage for enrollment. Eligible Pediatric Enrollees must be enrolled within [31[d35]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS36] Pediatric Enrollees who enroll in the Contractholder's medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

7.03 Except for an Employee absent from work due to a leave of absence governed by the "Family & Medical Leave Act of 1993" (P.L. 103.3), a Pediatric Enrollee will not be covered for any dental services received while an Employee is on strike, lay-off or leave of absence. Contractholder must inform the [Dentegra[DS37]/MPI] of any change in eligibility as required under section 3.01.

Coverage will resume the first day of the month after the Employee returns to work, provided the Contractholder submits the request to [Dentegra[DS38]/the MPI] that coverage be reactivated.

Benefits for such Pediatric Enrollee will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and Out-of-Pocket Maximums for the Pediatric Enrollee will resume as if the Employee was never gone.
- If coverage is reactivated in a different Calendar Year, new Deductibles and Out-of-Pocket Maximums will apply.

If an Employee is rehired within the same Calendar Year, Deductibles and Out-of-Pocket Maximums will resume as if the Employee was never gone.

7.04 Coverage will terminate when a Pediatric Enrollee loses dependent status or reaches age 26.

Termination of Benefits on Loss of Eligibility
Dentegra will not pay for Benefits for any services received by a person who is not a Pediatric Enrollee at the time of treatment except for covered dental services incurred when the person was covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

7.05 **Continuation of Coverage Under COBRA**
When the employees of a Contractholder are covered under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), then in consideration of the payments specified in Article 3, Dentegra agrees to provide Benefits to Pediatric Enrollees for whom continued coverage is elected pursuant to this section, provided:

- continuation of coverage is required to be offered under COBRA;
- the Pediatric Enrollee requests the continuation within the time frame allowed;
- the Contractholder notifies [Dentegra[DS39]/the MPI] that the Pediatric Enrollee has elected to continue coverage under COBRA;
- Dentegra receives the required Premium for the continued coverage;
- this Contract stays in force.

Dentegra does not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

ARTICLE 8
CHOICE OF PROVIDERS FOR PEDIATRIC BENEFITS

8.01 Pediatric Enrollees may choose a Provider from Dentegra's panel of PPO Providers or Pediatric Enrollees may choose a Non-Dentegra Provider. A list of Providers can be obtained by accessing the Dentegra Provider directory at dentegra.com. A representative can provide specific Provider information over the phone or by mail. Pediatric Enrollees are responsible for verifying whether the selected Provider is a Dentegra Provider. Additionally, Pediatric Enrollees should always confirm with the Provider's office that a listed Provider is still a participating Dentegra Provider. Dentegra does not guarantee that any particular Provider will be available.

Dentegra Provider
Selecting a Dentegra Provider potentially allows the greatest reduction in Pediatric Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon. Also, the services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A.

Non-Dentegra Provider
If a Provider is a Non-Dentegra Provider, the amount charged to Pediatric Enrollees may be above that accepted by the Dentegra Providers, and Pediatric Enrollees will still be responsible for Coinsurance and other cost-sharing, including balance billed amounts, after the Out-of-Pocket Maximum is met. Costs incurred by the patient with a Non-Dentegra Provider do not count towards the Out-of-Pocket Maximum. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

Additional advantages of using a Dentegra Provider:

- The Dentegra Provider must accept assignment of Benefits, meaning Dentegra Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Pediatric Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra Provider's Contracted Fee.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

ARTICLE 9
ADDITIONAL DEFINITIONS FOR ADULT BENEFITS

Terms when capitalized in this document have defined meanings, given either in the section below or within the Contract sections.

9.01 **Contract Benefit Level** -- the percentage of the Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment C.

9.02 **Deductible** -- a dollar amount that an Enrollee and/or the Dependent Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits as shown in Attachment C.

9.03 **Dependent Enrollee** -- an Eligible Dependent enrolled to receive Benefits; may also be referred to as "Enrollee".

9.04 **Eligible Dependent** -- a dependent of an Eligible Employee eligible for Benefits under Article 10.

9.05 **Eligible Employee** -- any employee eligible for Benefits under Article 10.

9.06 **Enrollee's Effective Date of Coverage** -- the date the [Contractholder[DS40]/MPI] reports coverage will begin for each Enrollee.

9.07 **Patient Pays** -- Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

9.08 **Primary Enrollee--** an Eligible Employee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee".

9.09 **Spouse** -- a person related to or a partner of the Eligible Employee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Eligible Employee resides; and
- as may be recognized by the Contractholder.

ARTICLE 10
ELIGIBILITY AND ENROLLMENT FOR ADULT BENEFITS

10.01 **Eligible Employees**
Eligible Employees are employees of Contractholder to whom Contractholder offers coverage.

10.02 **Eligible Dependents**
Eligible Dependents are the Spouse and children to age 26. [Additionally[DS41], children from birth to age 19 are covered for services not covered under Pediatric Benefits]. Dependent children of the Eligible Employee include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by the applicable state regulations and as may be recognized by the Contractholder.

A dependent unmarried child 26 years of age or older may continue eligibility if:

1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on the Eligible Employee or Spouse for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Eligible Employee or Spouse for support because of a mental or physical disability that began before he or she reached the limiting age.

Dependents on active military duty are not eligible.

10.03 **Enrollment of Eligible Employees and/or Dependent Enrollees**
The [Contractholder[DS42]/MPI] is responsible for establishing the Enrollee's Effective Date of Coverage for enrollment. Eligible Enrollees must be enrolled within [31[d43]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS44] Employees and/or Dependent Enrollees who enroll in the Contractholder's medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

10.04 Except for an employee absent from work due to a leave of absence governed by the "Family & Medical Leave Act of 1993" (P.L. 103.3), an Enrollee will not be covered for any dental services received while an Eligible Employee is on strike, lay-off or leave of absence. Contractholder must inform [Dentegra[DS45]/the MPI] of any change in eligibility as required under section 3.01.

Coverage will resume the first day of the month after the employee returns to work, provided the Contractholder submits the request to [Dentegra[DS46]/the MPI] that coverage be reactivated.

Benefits for such will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and maximums will resume as if the Eligible Employee were never gone.
- If coverage is reactivated in a different Calendar Year, new Deductibles and maximums will apply.

If an employee is rehired within the same Calendar Year, Deductibles and maximums will resume as if the Eligible Employee was never gone.

10.05 *Termination of Benefits on Loss of Eligibility*
Dentegra will not pay for Benefits for any services received by a person who is not an Enrollee at the time of treatment except for covered dental services incurred when the person was covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

10.06 **Continued Coverage Under USERRA**
As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if a Primary Enrollee is covered by this Contract on the date his or her USERRA leave of absence begins, the Primary Enrollee may continue dental coverage for himself or herself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of: 24 months beginning on the date the leave of absence begins or the date the Primary Enrollee fails to return to work within the time required by USERRA. For USERRA leave that extends beyond 31 days, the Premium for continuation of coverage will be the same as for COBRA coverage.

10.07 **Continuation of Coverage Under COBRA**
When the Eligible Employees of a Contractholder are covered under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), then in consideration of the payments specified in Article 3, Dentegra agrees to provide the Benefits to Enrollees who elect continued coverage pursuant to this section, provided:

- Continuation of coverage is required to be offered under COBRA;
- The Enrollee requests the continuation within the time frame allowed;
- The Contractholder notifies [Dentegra[DS47]/the MPI] that the Enrollee has elected to continue coverage under COBRA;
- Dentegra receives the required Premium for the continued coverage;
- This Contract stays in force.

Dentegra does not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

ARTICLE 11
CHOICE OF PROVIDERS FOR ADULT BENEFITS

11.01 Enrollees may choose a Provider from Dentegra's panel of PPO Providers or Enrollees may choose a Non-Dentegra Provider. A list of Dentegra Providers can be obtained at Dentegra's website (dentegra.com). Providers are regularly added to or deleted from the list. Enrollees are responsible for verifying whether the selected Provider is a PPO Provider. Additionally, Enrollees should always confirm with the Provider's office that a listed Provider is still a participating Dentegra Provider.

Dentegra Provider
Selecting a Dentegra Provider potentially allows the greatest reduction in Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon.

Non-Dentegra Provider
If a Provider is a Non-Dentegra Provider, the amount charged to Enrollees may be above that accepted by the Dentegra Providers. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

Additional Obligations of Dentegra Provider:

- The Dentegra Provider must accept assignment of Benefits, meaning Dentegra Providers will be paid directly by Dentegra after satisfaction of the Deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra Provider's Contracted Fee.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

ARTICLE 12
ATTACHMENTS

These documents are attached to this Contract and made a part of it:

Attachment A Deductibles, Maximums and Contract Benefit Levels For Pediatric Benefits
Attachment B Services, Limitations and Exclusions For Pediatric Benefits
Attachment B-1 Schedule of Covered Services For Pediatric Benefits
Attachment C Deductibles, Maximums and Contract Benefit Levels For Adult Benefits
Attachment D Services, Limitations and Exclusions For Adult Benefits
Attachment E Group Variables

[logo[D1]]

Dentegra® Dental PPO

Children's [Plan 70/85[D2]] + Adult [Basic/Preferred[D3]]

Group Name[DR4]

Group No.[DR5]

Effective Date[DR6]

[Revised][DR7]

Provided by:

Dentegra Insurance Company

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[dentegra[D8].com]
[MPI website and phone number[D9]]

Table of Contents

Attachments

INTRODUCTION

Your employer has chosen Dentegra® Insurance Company ("Dentegra") to meet your dental insurance needs. This plan is underwritten by Dentegra and administered by Delta Dental Insurance Company. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Provider, but to see him/her on a regular basis.

Essential Health Benefit Plan - The Essential Health Benefit Plan ("Pediatric Benefits") provides coverage to Eligible Pediatric Enrollees who are dependent children of employees to whom Contractholder offers coverage. Such children are eligible for Benefits under the Contract from birth to age 26. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulation and as may be recognized by the Contractholder.

Supplemental Adult Group Benefit Plan - The Adult Group Benefit Plan provides coverage for Eligible Employees and/or Eligible Dependents which include the Eligible Employee's Spouse and children from age 19 to age 26. [Additionally, [D10]children from birth to age 19 are covered for services not covered under Pediatric Benefits.] Dependent children of the Eligible Employee include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulations and as may be recognized by the Contractholder.

Using This Evidence of Coverage - This Evidence of Coverage booklet, which includes Attachment A Deductibles, Maximums and Contract Benefit Levels ("Attachment A") , Attachment B Services, Limitations and Exclusions ("Attachment B"); Attachment B-1 Schedule of Covered Services and Limitations for Pediatric Benefits ("Attachment B-1"); Attachment C Deductibles, Maximums and Contract Benefit Levels for Adult Benefits ("Attachment C") and Attachment D Services, Limitations and Exclusions for Adult Benefits ("Attachment D"), discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. "We," "us" and "our" always refer to Dentegra. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Contract.

The benefit explanations contained in this booklet are subject to all provisions of the Contract on file with your employer ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Notice: *This booklet is a summary of your group dental program and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.*

Contact Us

For more information please visit our website at[D11] [dentegra.com] or call our Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at [877-280-4204] [D12]to obtain information about Enrollee eligibility and Benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850][D13]

Anthony S. Barth, Vice Chairman

DEFINITIONS

Terms when capitalized in your Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits: the amounts that Dentegra will pay for dental services under the Contract.

Calendar Year: the 12 months of the year from January 1 through December 31.

Claim Form: the standard form used to file a claim, request a Pre-Treatment Estimate or request Prior Authorization for medically necessary orthodontics .

Contract: the agreement between Dentegra and the Contractholder, including any attachments.

Contractholder: a small group employer named on this booklet's cover.

Contract Term: the period during which the Contract is in effect.

Contract Year: the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Dentegra PPO℠ Provider (Dentegra Provider): a Provider who contracts with Dentegra and agrees to accept Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO dental plan.

Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee): the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Enrollees.

Effective Date: the original date the contract starts. This date is given on this booklet's cover.

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstance, the Maximum Contract Allowance for services provided:

- by Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee; or
- by Non-Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic area.

[**Medical**[DS14] **Plan Issuer ("MPI"):** the entity providing the medical plan that is issued and delivered to Contractholder with this dental plan as a Packaged Offering.]

Non-Dentegra Provider: a Provider who is not a Dentegra Provider and has not agreed to accept the Dentegra Provider's Contracted Fees.

Open Enrollment Period: the period of the year that the [employer[DS15]/MPI] has established during which Eligible Employees may change coverage selections for the next Contract Year.

[**Packaged**[DS16] **Offering:** the selection of a separate medical plan provided by the MPI bundled with this dental plan provided by Dentegra.]

Pre-Treatment Estimate: an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Enrollee.

Procedure Code: the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

Program Allowance: the amount determined for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Qualifying Status Change: a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of employee);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee, Spouse or child moves);
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

Single Procedure: a dental procedure that is assigned a separate procedure code.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

PREMIUMS:

You may be required to contribute towards the cost of coverage for yourself, Pediatric Enrollees and Dependent Enrollees.

We may cancel the Contract 31 days after written notice to the Contractholder if monthly premiums are not paid when due.

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

We will pay Benefits for the dental services described in Attachments B and D. We will pay Benefits only for covered services. The Contract covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and exclusions will be applied for the period the person is an Enrollee under any Dentegra program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional waiting periods, if any, are listed in Attachments A and C.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services as shown in Attachments A and C, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Coinsurance for covered services. Eligible Employee's group has chosen to require Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. If the Provider discounts, waives

or rebates any portion of the Coinsurance, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled "Selecting Your Provider" and "How Claims Are Paid" for more information.

Deductible

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts, if any, are listed in Attachments A and C. Deductibles apply to all benefits unless otherwise noted. Only the Provider's fees you pay for covered benefits will count toward the Deductible.

Maximum Amount

A maximum amount ("Maximum Amount" or "Maximum") is the maximum dollar amount we will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. We will pay the Maximum Amount(s), if applicable, shown in Attachments A and C for Benefits under the Contract.

Prior Authorization for Medically Necessary Orthodontics

Orthodontic treatment is covered under Pediatric Benefits, which are shown in Attachments A, B and B-1, only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization ("Prior Authorization") is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under the Contract for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Contract when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date Benefits under the Contract are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage ends; or
- the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

Coordination of Benefits

We coordinate the Benefits under the Contract with your benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. If this plan is the "primary" plan, we will not reduce Benefits. If this plan is the "secondary" plan, we may reduce Benefits otherwise payable under the Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

How do we determine which Plan is the "primary" plan?

(1) The plan covering the Enrollee as an employee is primary over a plan covering the Enrollee as a dependent.

(2) The plan covering the Enrollee as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

a) Secondary to the plan covering the insured person as a dependent and

b) Primary to the plan covering the insured person as other than a dependent (e.g. a retired employee),

then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.

(3) Except as stated in paragraph (4), when this plan and another plan cover the same child as a dependent of different persons, called parents:

a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but

b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

(5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).

(6) The benefits of a plan which covers an insured person as an employee who is neither laid-off nor retired are determined before those of a plan which covers that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (6) is ignored.

(7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:

a) First, the benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);

b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(8) If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the plan which covered that insured person for the shorter term.

(9) When determination cannot be made in accordance with the above for Pediatric Benefits, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

SELECTING YOUR PROVIDER

Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support the right to freedom of choice regarding your Provider. Freedom of choice assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider. In addition, family members can see different Providers.

Remember, you enjoy the greatest Benefits—including out-of-pocket savings—when you choose a Dentegra Provider. To take full advantage of your Benefits, we highly recommend you verify a dentist's participation status within a Dentegra network with your dental office before each appointment. Review the sections titled "How Claims Are Paid", "Choice of Provider for Pediatric Benefits" and "Choice of Provider for Adult Benefits" for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Dentist selection and how that may impact your out-of-pocket costs.

Locating a Dentegra Provider

There are two ways in which you can locate a Dentegra Provider near you:

- You may access information through our website at [dentegra.com]. This website includes a Provider search function allowing you to locate Dentegra Providers by location, specialty and network type; or
- You may also call our Customer Service Center toll-free at [877-280-4204] and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — Dentegra Provider

Payment for covered services performed for you by a Dentegra Provider is calculated based on the Maximum Contract Allowance Dentegra Providers have agreed to accept the Dentegra Provider's Contracted Fee as the full charge for covered services..

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in the Attachments A and C. Dentegra's payment is sent directly to the Dentegra Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Non-Dentegra Provider

Payment for services performed for you by a Non-Dentegra Provider is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in the Attachments A and C. Non-Dentegra Providers have no agreement with Dentegra and are free to balance bill you for any difference between what Dentegra pays and the Submitted Fee.

When dental services are received from a Non-Dentegra Provider, Dentegra's payment is sent directly to the Primary Enrollee, unless you have assigned the Benefits to the Provider. You are responsible for payment of the Non-Dentegra Provider's Submitted Fee. Non-Dentegra Providers will bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Provider and then submit a claim to us for reimbursement. Since our payment for services you receive may be less than the Non-Dentegra Provider's actual charges, your out-of-pocket cost may be significantly higher. We advise you of any Coinsurance as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

How to Submit a Claim

Dentegra does not require special Claim Forms. However, most dental offices have Claim Forms available. Dentegra Providers will fill out and submit your claims paperwork. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

CLAIMS APPEALS

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You and your Provider have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why you believe the denial was wrong. You may also ask us to examine any additional information you include that may support the appeal or grievance.

Send appeal or grievance to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1809]

We will send you a written acknowledgment within five (5) days upon receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, we shall consult with a Dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. We will send you a decision within 30 days after receipt of your appeal or grievance.

If the Enrollee believe he/she needs further review of their appeal or grievance, he/she may contact his/her state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), he/she may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if he/she has questions about the rights under ERISA. He or she may also bring a civil action under Section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GENERAL PROVISIONS

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to you as may be required to administer the claim. Dentegra, at its own expense, has the right to have an Enrollee examined by a dental consultant retained by us, as often as necessary, in or near your community or a residence, while a claim is pending. We will in every case hold such information and records confidential.

Notice of Claim Form
We will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss
We must be given written proof of loss within 12 months after the date of the loss and must include information regarding other group coverage if applicable. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to us within 12 months of the termination of the Contract.

Time of Payment
Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. We will notify you and your Provider of any additional information needed to process the claim within this 30 day period.

To Whom Benefits Are Paid
It is not required that the service be provided by a specific Dentist. Payment for services provided by a Dentegra Provider will be made directly to the Dentist. Any other payments provided by the Contract will be made to you, unless he/she requests when filing a proof of claim that the payment be made directly to the dentist providing the services. All Benefits not paid to the Provider will be payable to you, the Primary Enrollee or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

Misstatements on Application; Effect
In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all statements made by you or the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under the Contract, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement made with intent to deceive which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same Premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the Premium to reflect your actual circumstances at enrollment.

Legal Actions
No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the Contract, nor will an action be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Conformity With Prevailing Laws
All legal questions about the Contract will be governed by the state of Tennessee where the Contract was entered into and is to be performed. Any part of the Contract which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

ADDITIONAL DEFINITIONS FOR PEDIATRIC BENEFITS

Terms when capitalized in the Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Contract Benefit Level -- the percentage of the Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment A.

Deductible -- a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits as shown in Attachment A.

Eligible Pediatric Enrollee: a person eligible for Benefits under the Contract.

Employee: an individual employed by the Contractholder and who has opted to cover his/her child(ren) under the Contract.

Out-of-Pocket Maximum: the maximum amount a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Provider even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

Patient Pays: the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as “Dentegra Pays” on the claims statement when a claim is processed.

Pediatric Enrollee: an Eligible Pediatric Enrollee enrolled in the plan to receive Benefits; may also be referred to as “Enrollee”.

Pediatric Enrollee’s Effective Date of Coverage: the date the [Contractholder[DS17]/MPI] reports coverage will begin for each Pediatric Enrollee.

ELIGIBILITY AND ENROLLMENT FOR PEDIATRIC BENEFITS

Eligible Pediatric Enrollee

Eligible Pediatric Enrollees are dependent children of Employees to whom Contractholder offers coverage. Such dependent children are eligible for Benefits under the Contract from birth to age 26.

Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by the applicable state regulations and as may be recognized by the Contractholder.

Pediatric Enrollees serving on active military duty are not eligible.

Enrollment of Eligible Pediatric Enrollees

The [Contractholder[DS18]/MPI] is responsible for establishing Pediatric Enrollee’s Effective Date of Coverage for enrollment. . Eligible Pediatric Enrollees must be enrolled within [31[d19]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS20] Pediatric Enrollees who enroll in the Contractholder’s medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

Coverage will terminate when a Pediatric Enrollee loses dependent status or reaches age 26.

Continuation of Benefits

We will not pay for any services/treatment received after the Pediatric Enrollee’s coverage ends. However, we will pay for covered services incurred while he/she were eligible if the procedures were completed within 31 days of the date his/her coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence
Pediatric Enrollees will not be covered for any dental services received while the Employee is on strike, lay-off, leave of absence, other than as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Coverage will resume the first day of the month after the Employee returns to work, provided the Contractholder submits the requests to [Dentegra[DS21]/the MPI] that coverage be reactivated.

Benefits for Pediatric Enrollees will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and Out-of-Pocket Maximums will resume for the Pediatric Enrollee as if the Employee was never gone.

If coverage is reactivated in a different Calendar Year, new Deductibles and Out-of-Pocket Maximums will apply.

If an Employee is rehired within the same Calendar Year, Deductibles and Out-of-Pocket Maximums for the Pediatric Enrollee will resume as if the Employee was never gone.

*Coverage for Pediatric Enrollees is not affected if the Employee takes a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If the Employee is currently paying any part of the premium, he/she may choose to continue coverage. If the Employee does not continue coverage during the leave, he/she can resume coverage for Pediatric Enrollees on their return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act does not apply to all companies, only those that meet certain size guidelines. See the Human Resources Department for complete information.

Continuation of Coverage Under COBRA
COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for the Pediatric Enrollee who loses employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA.

CHOICE OF PROVIDER FOR PEDIATRIC BENEFITS

Pediatric Enrollees may choose a Provider from Dentegra's panel of PPO Providers or Pediatric Enrollees may choose a Non-Dentegra Provider. A list of Providers can be obtained by accessing the Dentegra Provider Directory at [dentegra.com]. A representative can provide specific Provider information over the phone or by mail. Pediatric Enrollees are responsible for verifying whether the selected Provider is a Dentegra Provider. Additionally, Pediatric Enrollees should always confirm with the Provider's office that a listed Provider is still a participating Dentegra Provider. Dentegra does not guarantee that any particular Provider will be available.

Dentegra Provider

Selecting a Dentegra Provider potentially allows the greatest reduction in Pediatric Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon. Also, the services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A.

Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged to Pediatric Enrollees may be above that accepted by the Dentegra Providers, and Pediatric Enrollees will still be responsible for Coinsurance and other cost-sharing, including balance billed amounts, after the Out-of-Pocket Maximum is met. Costs incurred by the patient with a Non-Dentegra Provider do not count towards the Out-of-Pocket Maximum. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

Additional advantages of using a Dentegra Provider:

- The Dentegra Provider must accept assignment of Benefits, meaning Dentegra Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Pediatric Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra Provider's Contracted Fee.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

ADDITIONAL DEFINITIONS FOR ADULT BENEFITS

Terms when capitalized in the Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Contract Benefit Level: percentage of Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment C.

Deductible: a dollar amount that an Enrollee and/or Dependent Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits; may also be referred to as "Enrollee".

Eligible Dependent: an Eligible Dependent enrolled to receive Benefits.

Eligible Employee: any employee eligible for Benefits.

Enrollee's Effective Date of Coverage: the date the [Contractholder[DS22]/MPI] reports coverage will begin for each Enrollee.

Patient Pays: Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

Primary Enrollee: an Eligible Employee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee".

Spouse: a person related to or a partner of the Eligible Employee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Eligible Employee resides; and

- as may be recognized by the Contractholder.

ELIGIBILITY AND ENROLLMENT FOR ADULT BENEFITS

Eligible Employees

Employees of Contractholder to whom Contractholder offers coverage.

Eligible Dependents

Eligible Dependents are the Spouse and dependent children to age 26. [Additionally, [D23]children from birth to age 19 are covered for services not covered under the Pediatric Benefits.] Dependent children of the Eligible Employee include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by the applicable state regulations and as may be recognized by the Contractholder.

A dependent unmarried child 26 years of age or older may continue eligibility if:

- he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
- he or she is chiefly dependent on the Eligible Employee or Spouse for support; and
- proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Eligible Employee or Spouse for support because of a mental or physical disability that began before he or she reached the limiting age.

Dependents serving on active military duty are not eligible.

Enrollment of Eligible Employees and/or Dependent Enrollees

The [Contractholder[DS24]/MPI] is responsible for establishing the Enrollee's Effective Date of Coverage for enrollment. Eligible Enrollees must be enrolled within [31[d25]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS26] Employees and/or Dependent Enrollees who enroll in the Contractholder's medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

Continuation of Benefits

We will not pay for any services/treatment received after the Enrollee's coverage ends. However, we will pay for covered services incurred while he/she was eligible if the procedures were completed within 31 days of the date your coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence

Enrollees will not be covered for any dental services received while the Eligible Employee is on strike, lay-off, leave of absence, other than [an approved leave of absence or] as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Coverage will resume the first day of the month after the Eligible Employee returns to work, provided the Contractholder submits the requests to [Dentegra[DS27]/the MPI] that coverage be reactivated.

Benefits for Enrollees will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and maximums will resume as if you were never gone; or
- If coverage is reactivated in a different Calendar Year, new Deductibles and maximums will apply.

If the Eligible Employee is rehired within the same Calendar Year, Deductibles and Maximums will resume as if the Eligible Employee were never gone.

*Coverage for Enrollees is not affected if the Eligible Employee takes a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If the Eligible Employee is currently paying any part of your Premium, you may choose to continue coverage. If the Eligible Employee does not continue coverage during the leave, you can resume that coverage for Enrollees on their return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

Continued Coverage under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if the Primary Enrollee is covered by the Contract on the date his or her USERRA leave of absence begins, the Primary Enrollee may continue dental coverage for himself or herself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 24 months, beginning on the date the leave of absence begins, or;
- the date the Primary Enrollee fails to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the Premium for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under COBRA

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA.

CHOICE OF PROVIDER FOR ADULT BENEFITS

Enrollees may choose a Provider from Dentegra's panel of PPO Providers or Enrollees may choose a Non-Dentegra Provider. A list of Dentegra Providers can be obtained at Dentegra's website [(dentegra.com)]. Providers are regularly added to or deleted from the list. Enrollees are responsible for verifying whether the selected Provider is a PPO Provider. Additionally, Enrollees should always confirm with the Provider's office that a listed Provider is still a participating Dentegra Provider.

Dentegra Provider

Selecting a Dentegra Provider potentially allows the greatest reduction in Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon.

Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged to Enrollees may be above that accepted by the Dentegra Providers. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

Additional advantages of using a Dentegra Provider:

- The Dentegra Provider must accept assignment of Benefits, meaning Dentegra Providers will be paid directly by Dentegra after satisfaction of the Deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra Provider's Contracted Fee.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
(2) the insurer was not authorized to do business in this state;
(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) any policy of reinsurance (unless an assumption certificate was issued);
(3) interest rate yields that exceed an average rate;
(4) dividends;
(5) credits given in connection with the administration of a policy by a group contract holder;
(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association 150 3rd Avenue South, Suite 1600 Nashville, TN 37201

Tennessee Department of Commerce and Insurance 500 James Robertson Parkway Nashville,Tennessee 37243

NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to tell you how Dentegra protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate. These affiliates have also implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.
  For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.
- Uses and/or disclosures of PHI for payment.
  For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.
- Uses and/or disclosures of PHI for health care operations.
  For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.

Disclosures Without an Authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Disclosures Dentegra Makes With Your Authorization

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

Your Rights Regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the Dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your Dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by email. You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

Contact

You may contact the Privacy Department at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Phone: [877-280-4204]

This notice is effective on and after August 1, 2012

Attachment A
Deductibles, Maximums and Contract Benefit Levels for Pediatric Benefits
Dentegra Dental PPO
Children's Plan 85

Deductibles & Maximums	
Annual Deductible	$25 per Pediatric Enrollee each Calendar Year The annual Deductible is waived for Diagnostic and Preventive Services.
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Pediatric Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers*	
Individual	$700 each Calendar Year
Multiple Child	$1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount a Pediatric Enrollee must satisfy for covered dental services under the Contract during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If an Employee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO Providers†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Medically Necessary Orthodontic Services (requires Prior Authorization)	50%	50%

†Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

Attachment A
Deductibles, Maximums and Contract Benefit Levels for Pediatric Benefits
Dentegra Dental PPO
Children's Plan 70

Deductibles & Maximums	
Annual Deductible	$45 per Pediatric Enrollee each Calendar Year
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Pediatric Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers*	
Individual	$700 each Calendar Year
Multiple Child	$1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount a Pediatric Enrollee must satisfy for covered dental services under the Contract during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If an Employee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO Providers†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	50%	50%
Major Services	50%	50%
Medically Necessary Orthodontic Services (requires Prior Authorization)	50%	50%

†Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

Attachment B
Services, Limitations and Exclusions for Pediatric Benefits
Dentegra PPO
Children's Plan [85/70[D1]]

Description of Dental Services

Dentegra will pay or otherwise discharge the Contract Benefit Level shown in Attachment A for the services shown on Attachment B-1 when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthdontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a Prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

Limitations

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Dentegra will pay for oral examinations (except exams for observation) no more than twice in a Calendar Year. Only one (1) comprehensive evaluation is allowed in a Calendar Year and counts toward the oral examination frequency in the year provided. One (1) limited oral evaluation, problem-focused no more than once in a Calendar Year.

(5) X-ray limitations:

a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(6) Dentegra will pay for routine cleanings and topical application of fluoride solutions no more than twice in a Calendar Year, and periodontal cleanings in the presence of inflamed gums up to four (4) times in a Calendar Year. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings not to exceed four (4) procedures or any combination thereof in a Calendar Year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

(7) Space maintainer limitations:

a) Space maintainers are limited to the initial appliance.
b) Recementation of space maintainer is limited to once per lifetime.

c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(8) Sealants are limited as follows:
a) to permanent molars through age 18 if they are without caries (decay) or restorations on the occlusal surface.
b) do not include repair or replacement of a Sealant on any tooth within 36 months of its application.

(9) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.

(10) Dentegra will not cover to replace an amalgam or resin-based composite within 24 months of treatment if the service is provided by the same Provider/Provider office. Pefabricated stainless steel crowns are limited to once per Enrollee per tooth per lifetime. Replacement restorations within 24 months are included in the fee for the original restoration.

(11) Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 15.

(12) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only. It is a benefit for primary incisor teeth up to age six (6) and for primary molars and cuspids to age 11.

(13) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(14) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Retrograde fillings per root are limited to once in any 24-month period.

(17) Pin retention is covered not more than once in any 24-month period.

(18) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(19) Period ontal limitations:
a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
b) Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
f) One crown lengthening per tooth per lifetime.

(20) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(21) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(22) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any 60 month period.

(23) Core buildup, including any pins, are covered not more than once in any 60 month period.

(24) Post and core services are covered not more than once in any 60 month year period.

(25) Crown repairs are covered not more than once in any 60 month period.

(26) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(27) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(28) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Removable cast base partial dentures are limited to Enrollees age 12 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.

(29) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(30) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a (6) month period by the same Provider/Provider office.

(31) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Contractholder's prior plan, if applicable

(32) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments and relining are limited to one (1) per arch in a 36-month period.
   c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
   d) Recementation of fixed partial dentures is limited to once in a lifetime.

(33) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period.

(34) Athletic mouth guards are limited to one (1) per 12 consecutive month period.

(35) Internal bleaching of discolored teeth shall not be provided for any tooth more than once each 36 months while the patient is an Enrollee under any Dentegra plan.

Exclusions

Dentegra does not pay Benefits for:

(1) services not included on Attachment B-1 Schedule of Covered Services except medically necessary Orthodontics provided a Prior Authorization is obtained.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) maxillofacial prosthetics.

(5) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).

(6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.

(8) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(10) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures if such procedures included in Attachment B-1.

(11) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(12) laboratory processed crowns for Enrollees under age 12.

(13) fixed bridges and removable partials for Enrollees under age 16.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) overdentures.

(16) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(17) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(18) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(19) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(20) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(21) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(22) Deductibles and/or any service not covered under the dental plan.

(23) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(24) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan with Dentegra or the Contractholder's prior dental plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(25) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(26) endodontic endosseous implant.

Attachment B-1
Schedule of Covered Services and Limitations

Please note the following:

• Dentegra will pay Benefits for dental services described in this attachment when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

• Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

• The codes and nomenclature in this Schedule are copyright of the American Dental Association. This table represents codes and nomenclature excerpted from the version of Current Dental Terminology (CDT)© in effect at the date of this printing. Dentegra's administration of benefits, limitations and exclusions under this plan at all times will be based on the current version of CDT whether or not a revised table is provided.

Category	Procedure Code	Procedure Description	Limitations
D&P	D0120	Periodic oral evaluation - established patient	2 in a calendar year
D&P	D0140	Limited oral evaluation - problem focused	1 in a calendar year
D&P	D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	
D&P	D0150	Comprehensive oral evaluation - new or established patient	1 in a calendar year
D&P	D0160	Detailed and extensive oral evaluation - problem focused, by report	problem focused, by report
D&P	D0180	Comprehensive periodontal evaluation - new or established patient	2 in a calendar year
D&P	D0210	Intraoral - complete series of radiographic images	Limited to 1 every 5 years
D&P	D0220	Intraoral - periapical first radiographic image	
D&P	D0230	Intraoral - periapical each additional radiographic image	
D&P	D0240	Intraoral - occlusal radiographic image	
D&P	D0250	Extraoral - first radiographic image	
D&P	D0260	Extraoral - each additional radiographic image	
D&P	D0270	Bitewing - single radiographic image	
D&P	D0272	Bitewings - two radiographic images	2 in a calendar year
D&P	D0273	Bitewings - three radiographic images	2 in a calendar year
D&P	D0274	Bitewings - four radiographic images	2 in a calendar year
D&P	D0277	Vertical bitewings - 7 to 8 radiographic images	
D&P	D0330	Panoramic radiographic image	

Category	Procedure Code	Procedure Description	Limitations
D&P	D0425	Caries susceptibility tests	
D&P	D1110	Prophylaxis - adult	2 in a calendar year
D&P	D1120	Prophylaxis - child	2 in a calendar year
D&P	D1206	Topical application of fluoride varnish	
D&P	D1208	Topical application of fluoride	2 in a calendar year
D&P	D1351	Sealant - per tooth	1 per tooth every 36 months
D&P	D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	
D&P	D1510	Space maintainer - fixed - unilateral	
D&P	D1515	Space maintainer - fixed - bilateral	
D&P	D1520	Space maintainer - removable - unilateral	
D&P	D1525	Space maintainer - removable - bilateral	
D&P	D1550	Re-cementation of space maintainer	
Basic	D2140	Amalgam - one surface, primary or permanent	1 every 24 month period
Basic	D2150	Amalgam - two surfaces, primary or permanent	1 every 24 month period
Basic	D2160	Amalgam - three surfaces, primary or permanent	1 every 24 month period
Basic	D2161	Amalgam - four or more surfaces, primary or permanent	1 every 24 month period
Basic	D2330	Resin-based composite - one surface, anterior	1 every 24 month period
Basic	D2331	Resin-based composite - two surfaces, anterior	1 every 24 month period
Basic	D2332	Resin-based composite - three surfaces, anterior	1 every 24 month period
Basic	D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	1 every 24 month period
Basic	D2391	Resin-based composite - one surface, posterior	1 every 24 month period
Basic	D2392	Resin-based composite - two surfaces, posterior	1 every 24 month period
Basic	D2393	Resin-based composite - three surfaces, posterior	1 every 24 month period
Basic	D2394	Resin-based composite - four or more surfaces, posterior	1 every 24 month period
Major	D2510	Inlay - metallic - one surface	
Major	D2520	Inlay - metallic - two surfaces	
Major	D2530	Inlay - metallic - three or more surfaces	
Major	D2542	Onlay - metallic-two surfaces	Limited to 1 every 5 years
Major	D2543	Onlay - metallic-three surfaces	Limited to 1 every 5 years
Major	D2544	Onlay - metallic-four or more surfaces	Limited to 1 every 5 years

Category	Procedure Code	Procedure Description	Limitations
Major	D2740	Crown - porcelain/ceramic substrate	
Major	D2750	Crown - porcelain fused to high noble metal	Limited to 1 every 5 years
Major	D2751	Crown - porcelain fused to predominantly base metal	Limited to 1 every 5 years
Major	D2752	Crown - porcelain fused to noble metal	Limited to 1 every 5 years
Major	D2780	Crown - 3/4 cast high noble metal	Limited to 1 every 5 years
Major	D2781	Crown - 3/4 cast predominantly base metal	Limited to 1 every 5 years
Major	D2782	Crown - 3/4 cast noble metal	Limited to 1 every 5 years
Major	D2783	Crown - 3/4 porcelain/ceramic	Limited to 1 every 5 years
Major	D2790	Crown - full cast high noble metal	Limited to 1 every 5 years
Major	D2791	Crown - full cast predominantly base metal	Limited to 1 every 5 years
Major	D2792	Crown - full cast noble metal	Limited to 1 every 5 years
Major	D2794	Crown - titanium	Limited to 1 every 5 years
Major	D2910	Recement inlay, onlay, or partial coverage restoration	Once per 6-month period
Major	D2920	Recement crown	Once per 6-month period
Basic	D2930	Prefabricated stainless steel crown - primary tooth	
Basic	D2931	Prefabricated stainless steel crown - permanent tooth	
Major	D2950	Core buildup, including any pins	Limited to 1 every 5 years
Major	D2951	Pin retention - per tooth, in addition to restoration	Limited to 1 every 24 months
Major	D2954	Prefabricated post and core in addition to crown	Limited to 1 every 5 years
Major	D2980	Crown repair necessitated by restorative material failure	
Major	D2981	Inlay repair necessitated by restorative material failure	
Major	D2982	Onlay repair necessitated by restorative material failure	
Major	D2983	Veneer repair necessitated by restorative material failure	
Basic	D2990	Resin infiltration of incipient smooth surface lesions	
Major	D3110	Pulp cap - direct (excluding final restoration)	
Major	D3120	Pulp cap - indirect (excluding final restoration)	
Major	D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	
Major	D3221	Pulpal debridement, primary and permanent teeth	

Category	Procedure Code	Procedure Description	Limitations
Major	D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	
Major	D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	
Major	D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	
Major	D3310	Endodontic therapy, anterior tooth (excluding final restoration)	
Major	D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	
Major	D3330	Endodontic therapy, molar (excluding final restoration)	
Major	D3346	Retreatment of previous root canal therapy - anterior	
Major	D3347	Retreatment of previous root canal therapy - bicuspid	
Major	D3348	Retreatment of previous root canal therapy - molar	
Major	D3351	Apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	
Major	D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	
Major	D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	
Major	D3354	Pulpal regeneration - (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration	
Major	D3410	Apicoectomy/periradicular surgery - anterior	
Major	D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
Major	D3425	Apicoectomy/periradicular surgery - molar (first root)	
Major	D3426	Apicoectomy/periradicular surgery (each additional root)	
Major	D3430	Retrograde filling - per root	
Major	D3450	Root amputation - per root	
Major	D3920	Hemisection (including any root removal), not including root canal therapy	

Category	Procedure Code	Procedure Description	Limitations
Major	D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Limited to 1 every 24 months
Major	D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4249	Clinical crown lengthening - hard tissue	
Major	D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	Limited to 1 every 24 months
Major	D4268	Surgical revision procedure, per tooth	
Major	D4270	Pedicle soft tissue graft procedure	
Major	D4273	Subepithelial connective tissue graft procedures, per tooth	
Major	D4275	Soft tissue allograft	
Major	D4276	Combined connective tissue and double pedicle graft, per tooth	
Major	D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	
Major	D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	
Major	D4341	Periodontal scaling and root planing - four or more teeth per quadrant	Limited to 1 every 24 months
Major	D4342	Periodontal scaling and root planing - one to three teeth per quadrant	Limited to 1 every 24 months
Basic	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Limited to 1 per lifetime
Major	D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	
Basic	D4910	Periodontal maintenance	Up to 4 periodontal maintenance procedures and up to 2 routine cleanings not to exceed 4
Major	D5110	Complete denture - maxillary	Limited to 1 every 5 years
Major	D5120	Complete denture - mandibular	Limited to 1 every 5 years
Major	D5130	Immediate denture - maxillary	Limited to 1 every 5 years

Category	Procedure Code	Procedure Description	Limitations
Major	D5140	Immediate denture - mandibular	Limited to 1 every 5 years
Major	D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years
Major	D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years
Major	D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years
Major	D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years
Major	D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	Limited to 1 every 5 years
Major	D5410	Adjust complete denture - maxillary	
Major	D5411	Adjust complete denture - mandibular	
Major	D5421	Adjust partial denture - maxillary	
Major	D5422	Adjust partial denture - mandibular	
Major	D5510	Repair broken complete denture base	
Major	D5520	Replace missing or broken teeth - complete denture (each tooth)	
Major	D5610	Repair resin denture base	
Major	D5620	Repair cast framework	
Major	D5630	Repair or replace broken clasp	
Major	D5640	Replace broken teeth - per tooth	
Major	D5650	Add tooth to existing partial denture	
Major	D5660	Add clasp to existing partial denture	
Major	D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	
Major	D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	
Major	D5710	Rebase complete maxillary denture	Limited to 1 in a 36-months
Major	D5711	Rebase complete mandibular denture	Limited to 1 in a 36-months
Major	D5720	Rebase maxillary partial denture	Limited to 1 in a 36-months
Major	D5721	Rebase mandibular partial denture	Limited to 1 in a 36-months
Major	D5730	Reline complete maxillary denture (chairside)	Limited to 1 in a 36-months
Major	D5731	Reline complete mandibular denture (chairside)	Limited to 1 in a 36-months
Major	D5740	Reline maxillary partial denture (chairside)	Limited to 1 in a 36-months
Major	D5741	Reline mandibular partial denture (chairside)	Limited to 1 in a 36-months

Category	Procedure Code	Procedure Description	Limitations
Major	D5750	Reline complete maxillary denture (laboratory)	Limited to 1 in a 36-months
Major	D5751	Reline complete mandibular denture (laboratory)	Limited to 1 in a 36-months
Major	D5760	Reline maxillary partial denture (laboratory)	Limited to 1 in a 36-months
Major	D5761	Reline mandibular partial denture (laboratory)	Limited to 1 in a 36-months
Major	D5850	Tissue conditioning, maxillary	
Major	D5851	Tissue conditioning, mandibular	
Major	D6010	Surgical placement of implant body: endosteal implant	Limited to 1 every 5 years
Major	D6053	Implant/abutment supported removable denture for completely edentulous arch	Limited to 1 every 5 years
Major	D6054	Implant/abutment supported removable denture for partially edentulous arch	Limited to 1 every 5 years
Major	D6055	Connecting bar - implant supported or abutment supported	Limited to 1 every 5 years
Major	D6056	Prefabricated abutment - includes modification and placement	Limited to 1 every 5 years
Major	D6057	Custom fabricated abutment - includes placement	Limited to 1 every 5 years
Major	D6058	Abutment supported porcelain/ceramic crown	Limited to 1 every 5 years
Major	D6059	Abutment supported porcelain fused to metal crown (high noble metal)	Limited to 1 every 5 years
Major	D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Limited to 1 every 5 years
Major	D6061	Abutment supported porcelain fused to metal crown (noble metal)	Limited to 1 every 5 years
Major	D6062	Abutment supported cast metal crown (high noble metal)	Limited to 1 every 5 years
Major	D6063	Abutment supported cast metal crown (predominantly base metal)	Limited to 1 every 5 years
Major	D6064	Abutment supported cast metal crown (noble metal)	Limited to 1 every 5 years
Major	D6065	Implant supported porcelain/ceramic crown	Limited to 1 every 5 years
Major	D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	Limited to 1 every 5 years
Major	D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	Limited to 1 every 5 years
Major	D6068	Abutment supported retainer for porcelain/ceramic FPD	Limited to 1 every 5 years
Major	D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	Limited to 1 every 5 years
Major	D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	Limited to 1 every 5 years

Category	Procedure Code	Procedure Description	Limitations
Major	D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	Limited to 1 every 5 years
Major	D6072	Abutment supported retainer for cast metal FPD (high noble metal)	Limited to 1 every 5 years
Major	D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	Limited to 1 every 5 years
Major	D6074	Abutment supported retainer for cast metal FPD (noble metal)	Limited to 1 every 5 years
Major	D6075	Implant supported retainer for ceramic FPD	Limited to 1 every 5 years
Major	D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	Limited to 1 every 5 years
Major	D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	Limited to 1 every 5 years
Major	D6078	Implant/abutment supported fixed denture for completely edentulous arch	Limited to 1 every 5 years
Major	D6079	Implant/abutment supported fixed denture for partially edentulous arch	Limited to 1 every 5 years
Major	D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	Limited to 1 every 5 years
Major	D6090	Repair implant supported prosthesis, by report	Limited to 1 every 5 years
Major	D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	Limited to 1 every 5 years
Major	D6094	Abutment supported crown - (titanium)	Limited to 1 every 5 years
Major	D6095	Repair implant abutment, by report	Limited to 1 every 5 years
Major	D6100	Implant removal, by report	Limited to 1 every 5 years
Major	D6194	Abutment supported retainer crown for FPD - (titanium)	Limited to 1 every 5 years
Major	D6210	Pontic - cast high noble metal	Limited to 1 every 5 years
Major	D6211	Pontic - cast predominantly base metal	Limited to 1 every 5 years
Major	D6212	Pontic - cast noble metal	Limited to 1 every 5 years
Major	D6214	Pontic - titanium	Limited to 1 every 5 years
Major	D6240	Pontic - porcelain fused to high noble metal	Limited to 1 every 5 years
Major	D6241	Pontic - porcelain fused to predominantly base metal	Limited to 1 every 5 years
Major	D6242	Pontic - porcelain fused to noble metal	Limited to 1 every 5 years
Major	D6245	Pontic - porcelain/ceramic	Limited to 1 every 5 years
Major	D6545	Retainer - cast metal for resin bonded fixed prosthesis	Limited to 1 every 5 years

Category	Procedure Code	Procedure Description	Limitations
Major	D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Limited to 1 every 5 years
Major	D6601	Inlay - porcelain/ceramic, three or more surfaces	Limited to 1 every 5 years
Major	D6604	Inlay - cast predominantly base metal, two surfaces	Limited to 1 every 5 years
Major	D6605	Inlay - cast predominantly base metal, three or more surfaces	Limited to 1 every 5 years
Major	D6613	Onlay - cast predominantly base metal, three or more surfaces	Limited to 1 every 5 years
Major	D6740	Crown - porcelain/ceramic	Limited to 1 every 5 years
Major	D6750	Crown - porcelain fused to high noble metal	Limited to 1 every 5 years
Major	D6751	Crown - porcelain fused to predominantly base metal	Limited to 1 every 5 years
Major	D6752	Crown - porcelain fused to noble metal	Limited to 1 every 5 years
Major	D6780	Crown - 3/4 cast high noble metal	Limited to 1 every 5 years
Major	D6781	Crown - 3/4 cast predominantly based metal	Limited to 1 every 5 years
Major	D6782	Crown - 3/4 cast noble metal	Limited to 1 every 5 years
Major	D6783	Crown - 3/4 porcelain/ceramic	Limited to 1 every 5 years
Major	D6790	Crown - full cast high noble metal	Limited to 1 every 5 years
Major	D6791	Crown - full cast predominantly base metal	Limited to 1 every 5 years
Major	D6792	Crown - full cast noble metal	Limited to 1 every 5 years
Major	D6794	Crown - titanium	Limited to 1 every 5 years
Major	D6930	Recement fixed partial denture	
Major	D6980	Fixed partial denture repair necessitated by restorative material failure	
Major	D7111	Extraction, coronal remnants - deciduous tooth	
Major	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
Major	D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	
Major	D7220	Removal of impacted tooth - soft tissue	
Major	D7230	Removal of impacted tooth - partially bony	
Major	D7240	Removal of impacted tooth - completely bony	
Major	D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
Major	D7250	Surgical removal of residual tooth roots (cutting procedure)	
Major	D7251	Coronectomy - intentional partial tooth removal	

Category	Procedure Code	Procedure Description	Limitations
Major	D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
Major	D7280	Surgical access of an unerupted tooth	
Major	D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	
Major	D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
Major	D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	
Major	D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
Major	D7471	Removal of lateral exostosis (maxilla or mandible)	
Major	D7510	Incision and drainage of abscess - intraoral soft tissue	
Major	D7910	Suture of recent small wounds up to 5 cm	
Major	D7921	Collection and application of autologous blood concentrate product	
Major	D7971	Excision of pericoronal gingiva	
Major	D7999	Unspecified oral surgery procedure, by report	
Basic	D9110	Palliative (emergency) treatment of dental pain - minor procedure	
Basic	D9220	Deep sedation/general anesthesia - first 30 minutes	
Basic	D9221	Deep sedation/general anesthesia - each additional 15 minutes	
Basic	D9241	Intravenous conscious sedation/analgesia - first 30 minutes	
Basic	D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	
D&P	D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	1 per lifetime
Basic	D9440	Office visit - after regularly scheduled hours	
Basic	D9610	Therapeutic parenteral drug, single administration	
Basic	D9612	Therapeutic parenteral drugs, two or more administrations, different medications	
Basic	D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	
Major	D9940	Occlusal guard, by report	1 in 12 months for patients 13 and older

Category	Procedure Code	Procedure Description	Limitations
Major	D9941	Fabrication of athletic mouthguard	
Major	D9974	Internal bleaching - per tooth	
Major	D9999	Unspecified adjunctive procedure, by report	

Attachment C
Deductibles, Maximums and Contract Benefit Levels for Adult Benefits
Dentegra Dental PPO
Adult Preferred

Deductibles & Maximums	
Annual Deductible	$50 per Enrollee each Calendar Year $150 per family each Calendar Year
Deductibles waived for	Diagnostic & Preventive
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Maximum	$1,000 per Enrollee per Calendar Year
[Annual [D2]Maximum Takeover	Dentegra will receive credit for any amount paid under the Contractholder's previous dental care plan from January 1st to the Effective Date. These amounts will be credited towards the Annual Maximum.]
Dental Accident Maximum	$1,000 per Enrollee per lifetime
[Dental[D3] Accident Maximum Takeover	Dentegra will receive credit for any amount paid under the Contractholder's previous dental care plan, if applicable, for Dental Accident Services. These amounts will be credited towards the maximum amounts payable for Dental Accident Services.]

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO℠ Provider†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic & Preventive	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Dental Accident	100%	100%

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

Waiting Periods:

- Major Services are limited to Enrollees who have been enrolled in the Contract for 12 consecutive months. Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date of Coverage reported by the Exchange for said Primary Enrollee and/or Dependent Enrollee.

Attachment C
Deductibles, Maximums and Contract Benefit Levels for Adult Benefits
Dentegra Dental PPO
Adult Basic

Deductibles & Maximums	
Annual Deductible	$50 per Enrollee each Calendar Year $150 per family each Calendar Year
Deductibles waived for	Diagnostic & Preventive
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Maximum	$1,000 per Enrollee per Calendar Year
[Annual Maximum Takeover	Dentegra will receive credit for any amount paid under the Contractholder's previous dental care plan from January 1st to the Effective Date. These amounts will be credited towards the Annual Maximum.]

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO℠ Provider†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic & Preventive	100%	100%
Basic Services	80%	80%

† Reimbursement is based on Dentegra PPO Contracted Fee for Dentegra PPO and Non-Dentegra Providers.

Attachment D
Services, Limitations and Exclusions for Adult Benefits
Dentegra Dental PPO
Adult Basic

Description of Dental Services

Dentegra will pay or otherwise discharge the Contract Benefit Level shown in Attachment C for the following services:

- **Diagnostic and Preventive Services**
  - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
  - (2) Preventive: routine cleanings.
  - (3) Specialist Consultations: opinion or advice requested by a general dentist.
- **Basic Services**
  - (1) Palliative: emergency treatment to relieve pain.
  - (2) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
- ***Note on additional Benefits during pregnancy***
  When an Enrollee is pregnant, Dentegra will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Contract include one (1) additional oral exam and one (1) additional routine cleaning. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. An example of an Optional Service is a composite restoration instead of an amalgam restoration on posterior teeth.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Dentegra will pay for oral examinations (except afterhours exams and exams for observation) and routine cleanings no more than twice in a Calendar Year**.** See note on additional Benefits during pregnancy.

(3) X-ray limitations:
  a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
  b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
  c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
  d) A complete intraoral series and panoramic film are each limited to once every 60 months.
  e) Bitewing x-rays are limited to one (1) time each Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(4) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(5) Specialist Consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.

(6) Dentegra will not cover to replace an amalgam, resin-based composite or prefabricated stainless steel crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

(7) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(8) Pin retention is covered not more than once in any 24-month period.

(9) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

Exclusions

Dentegra does not pay Benefits for:

(1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons.

(3) maxillofacial prosthetics.

(4) provisional and/or temporary restorations.

(5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

(6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.

(7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(10) interim implants.

(11) indirectly fabricated resin-based Inlays/Onlays.

(12) overdentures.

(13) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(14) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(15) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(16) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(17) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(18) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(19) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(20) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(21) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.

(22) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(23) endodontic endosseous implant.

(24) services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.

(25) services for implants (prosthetic appliances placed into or on the bone of the upper or lower jaw to retain or support dental prosthesis), their removal or other associated procedures.

(26) services or supplies for oral surgery, general anesthesia or IV sedation.

(27) services or supplies for endodontic treatment (procedures for removal of the nerve of the tooth and the treatment of the pulp cavity portion of the root of the tooth).

(28) services or supplies for periodontic treatment (procedures for the treatment of the gums and the bones supporting teeth).

(29) services or supplies for denture repairs (repair to partial or complete dentures including rebase procedures and relining).

(30) services or supplies for crowns and inlays/onlays for treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam, synthetic porcelain, or plastic restorations.

(31) services or supplies for prosthodontics (procedures for construction of fixed bridges, partial or completed dentures and the repair of fixed bridges).

Attachment D
Services, Limitations and Exclusions for Adult Benefits
Dentegra Dental PPO
Adult Preferred

Description of Dental Services

Dentegra will pay or otherwise discharge the Contract Benefit Level shown in Attachment C for the following services:

- **Diagnostic and Preventive Services**
  - (1) Diagnostic: procedures to aid the Provider in determining required dental treatment.
  - (2) Preventive: cleaning (periodontal cleaning in the presence of inflamed gums is considered to be a Basic Service for payment purposes).
  - (3) Specialist Consultations: opinion or advice requested by a general dentist.
- **Basic Services**
  - (1) General Anesthesia or IV Sedation: when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
  - (2) Palliative: emergency treatment to relieve pain.
  - (3) Restorative: amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).
  - (4) Periodontal Cleanings: periodontal maintenance.
- **Major Services**
  - (1) Crowns and Inlays/Onlays: treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
  - (2) Prosthodontics: procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
  - (3) Oral Surgery: extractions and certain other surgical procedures (including pre-and post-operative care).
  - (4) Endodontics: treatment of diseases and injuries of the tooth pulp.
  - (5) Periodontics: treatment of gums and bones supporting teeth.
  - (6) Denture Repairs: repair to partial or complete dentures, including rebase procedures and relining.
- **Dental Accident Services**
  An injury to the mouth or structures within the oral cavity which is caused by an external traumatic force. It does not include damage to the teeth which is the result of biting into food or other substances. Procedures shall include, but are not limited to, reimplantation, splinting and stayplate.
- ***Note on additional Benefits during pregnancy***
  When an Enrollee is pregnant, Dentegra will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or her Provider when the claim is submitted.

Limitations

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:
a) a composite restoration instead of an amalgam restoration on posterior teeth;
b) a crown where a filling would restore the tooth;
c) an inlay/onlay instead of an amalgam restoration; or
d) porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown).

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Dentegra will pay for oral examinations (except afterhours exams and exams for observation) and cleanings (including periodontal cleanings in the presence of inflamed gums or any combination thereof) no more than twice in a Calendar Year**.** A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. See note on additional Benefits during pregnancy.

(3) X-ray limitations:
a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to one (1) time each Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(4) Pulp vitality tests are allowed once per day when definitive treatment is not performed.

(5) Specialist Consultations, screenings of patients, and assessments of patients are limited to once per lifetime per Provider and count toward the oral exam frequency.

(6) Dentegra will not cover to replace an amalgam, resin-based composite or prefabricated stainless steel crowns within 24 months of treatment if the service is provided by the same Provider/Provider office. Replacement restorations within 24 months are included in the fee for the original restoration.

(7) Protective restorations (sedative fillings) are allowed once per tooth per lifetime when definitive treatment is not performed on the same date of service.

(8) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(9) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(10) Pin retention is covered not more than once in any 24-month period.

(11) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(12) Periodontal limitations:
a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. See note on additional Benefits during pregnancy.
b) Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.

(13) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(14) Crowns and Inlays/Onlays are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(15) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are covered not more than once in any 60 month period.

(16) Core buildup, including any pins, are covered not more than once in any 60 month period.

(17) Post and core services are covered not more than once in any 60 month year period.

(18) Crown repairs are covered not more than once in any 60 month period.

(19) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(20) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(21) Prosthodontic appliances implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.

(22) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(23) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a lifetime by the same Provider/Provider office.

(24) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Contractholder's prior plan, if applicable.

(25) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
a) Denture rebase is limited to one (1) per arch in a 24-month period and includes any relining and adjustments for six (6) months following placement.
b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments are limited to two (2) per arch in a Calendar Year and relining is limited to one (1) per arch in a six (6) month period.
c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
d) Recementation of fixed partial dentures is limited to once in a lifetime.

(26) Limitations on Dental Accident Services:
a) The dental accident must occur while the Enrollee is covered under the Contract.

b) Services and procedures must be provided within 180 days following the dental accident and while the Enrollee is covered under the Contract.

Exclusions

Dentegra does not pay Benefits for:

(1) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(2) cosmetic surgery or procedures for purely cosmetic reasons.

(3) maxillofacial prosthetics.

(4) provisional and/or temporary restorations.

(5) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.

(6) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, complete occlusal adjustments or Night Guards/Occlusal guards and abfraction.

(7) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(8) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(9) charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected endodontic and periodontal surgical procedures.

(10) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(11) interim implants.

(12) indirectly fabricated resin-based Inlays/Onlays.

(13) overdentures.

(14) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(15) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(16) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(17) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(18) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(19) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(20) Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

(21) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(22) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract

or was covered under any dental care plan with Denterga or the Contractholder's prior dental plan, if applicable. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(23) services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) including orthodontic related services such as cephalometric x-rays, oral/facial photographic images and diagnostic casts, surgical access of an unerupted tooth, placement of device to facilitate eruption of impacted tooth and surgical repositioning of teeth.

(24) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues).

(25) endodontic endosseous implant.

(26) services or supplies for sealants, fluoride, space maintainers, apexification and transseptal fiberotomy/supra crestal fiberotomy.

ATTACHMENT E
GROUP VARIABLES
[Information in this section is variable.]
for
[Contractholder*[D1] *Name]
[Group Number]

Effective Date:

Contract Term:

Premiums:
Monthly Amount:

[Per[D2] Primary Enrollee:	$	[XX]
Per Primary Enrollee and his/her Dependent Enrollee(s):**]**	$	[XX][D3]

Premiums are to be remitted to:

[[SF4]**Dentegra Insurance Company**
[[SF5]P.O. Box 1850
Alpharetta, GA 30023-1850]

[MPI][D6]
Street Address line 1
Street Address line 2
City, State Zip]

Payment Breakdown:

Contractholder shall pay:	[0-100]	%	for Employee
	[0-100][D7]	%	for Dependent Enrollees
Primary Enrollee shall pay:	[0-100]	%	for Employee
	[0-100][D8]	%	for Dependent Enrollees

Contractholder may charge persons electing continued coverage pursuant to Title X of P.L. 99 as permitted by law.

[Dentegra® Insurance Company]
[P.O. Box 1850[MD1]
Alpharetta, GA 30023-1850
dentegra.com]

Group Dental Insurance Application

Dentegra's Use ONLY
Group #:

AE: AM:

Name of Applicant:				**Fed ID/TIN#:**	
Type of Group: (employer)		**Type of Industry:**		**SIC Code:**	
Address:					
	(Street)	(City)		(Zip)	(County)
Mailing Address:					
Name of Contact Person:		**Telephone No.:**			
Fax No.:		**E-mail Address:**			

Billing Address if different:				*Contact:*	
TPA ☐ *No* ☐ *Yes*	*Fax:*		*E-mail:*	*Telephone #:*	

Contract Effective Date: **Length of Contract:**

Dentegra Dental PPO **Program Selection**	**Supplemental + Pediatric** ☐ Children's Plan 70 + Adult Basic ☐ Children's Plan 85 + Adult Preferred ☐ Children's Plan 70 + Adult Preferred ☐ Children's Plan 85 + Adult Basic		**Pediatric** ☐ Children's Plan 70 ☐ Children's Plan 85	
Benefits	**Adult Basic**	**Adult Preferred**	**Children's Plan 70**	**Children's Plan 85**
Services covered at				
Diagnostic & Preventive	100%	100%	100%	100%
Basic	80%	80%	50%	80%
Major	0%	50%	50%	50%
Orthodontics Medically Necessary *(Pediatric Only)*	Not a Benefit	Not a Benefit	50%	50%
Deductible Waived on D&P	☒ yes ☐ no	☒ yes ☐ no	☐ yes ☒ no	☒ yes ☐ no
Deductible per person	$50	$50	$40	$25
Deductible per family	$150	$150	$ Not Applicable	$ Not Applicable
Annual Maximum	$1000	$1000	None	None
Out-of-Pocket Maximum	Not Applicable	Not Applicable	$700 child / $1400 multi-child	$700 child / $1400 multi-child
Waiting Periods *(Major Benefits)*	12 months	12 months	0 months	0 months
Dental Accident Benefit	Not a Benefit	100% w/ $1000 Lifetime Maximum	Not a Benefit	Not a Benefit
Rates				
Per Person	$	$	$	$
Employer Contribution:	Per Primary Enrollee:	$	Per Dependent:	$

(Continued on next page)

Group Dental Application (Continued)

Applicant's Name: _____

Census	*# of Eligible Employees*						
# of Participating Adults (Incl. dependents age 19 – 26)				*# of Pediatric Dependents (to age 19)*		____	
Eligibility:	*# of Months:*	____	*or*	*# of Days:*	____	*or*	*Hours / week:* ____
New Hire Employee	☐ *1st day of the month following completion of eligibility*					☐ *Date of hire*	
Effective Date:	☐ *1st day of month following date of hire*				☐ *Day following completion of eligibility*		
Who is eligible:	☐ *All Employees*		☐ *Retired Employees*		____ *Part time employees*		
	☐ *Class of employees:* ____						

Payment Options

Billing Frequency will be monthly.

Your initial payment will include your first two months' premium.

A. Bank Account Debit ☐ Initial payment ☐ Recurring payments

Sample ⑆123456789⑆ 1234567899⑈ 0123

Routing number Account number

Type of Account ☐ Checking ☐ Savings

Routing Number ____	Account Number ____
Bank Name ____	Account Holder's Name ____

I hereby authorize Dentegra Insurance Company (Dentegra), its subsidiaries and affiliates to initiate automatic withdrawals from the account indicated above for the premiums due. For recurring withdrawals this authorization will remain in effect until Dentegra has received written notification from me of its termination and/or my payment obligation has been satisfied. If the payment amount changes, Dentegra will provide a minimum of 30 days' notice to me. I understand that I am responsible for any fees incurred due to my payment being rejected for processing by my bank.

Account Holder's Signature ____ Date ____

Credit Card	☐ Initial payment	☐ Recurring payments		
Type of account:	☐ VISA®	☐ MasterCard®	☐ American Express®	☐ Discover®

Card Number ____	Expiration Date ____

Cardholder's Name (as it appears on the credit card) ____ Issue Date ____

I hereby authorize Dentegra, its subsidiaries and affiliates to charge my credit card for premiums due. For recurring payments this authorization will remain in effect until Dentegra has received written notice from me of its termination. If the payment amount changes, Dentegra will provide a minimum of 30 days' notice to me.

Note: Any credit card refunds may be made by check.

Cardholder's Signature ____ Date ____

B. **Paper Check** (Please make payable to Dentegra Insurance Company) ☐ Initial payment

This program shall become effective only upon issuance of a written agreement executed by a duly authorized officer of Dentegra. In the absence of fraud or intentional misrepresentation of material fact, the statements in this application are deemed to be representations and not warranties. Any misrepresentation, omission, concealment of fact or incorrect statement which is material to the acceptance of risk may prevent recovery if, had the true facts been known to Dentegra we would not in good faith have issued the contract at the same premium rate.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Except as otherwise limited by the Health Insurance Portability and Accountability Act and its administrative simplification regulations ("HIPAA"), Applicant shall provide Dentegra with Protected Health Information ("PHI") for the proper implementation, administration and

management of the group dental services contract for which Applicant is applying. Dentegra agrees that the PHI will be held confidential and used or further disclosed only to administer the group dental program as described in the group dental contract or as permitted or required by law. Applicant and Dentegra shall comply with all the applicable federal and state laws and regulations relating to administrative simplification, security and privacy of PHI, including the terms of any business associate addendum that may be required as part of the group dental contract to be executed between Applicant and Dentegra.

Applicant understands he/she will receive an electronic version of the evidence of coverage booklet for distribution to all employees/ members covered under the contract unless the box below is checked to request hard copies.

☐ Applicant requests hard copies of evidence of coverage booklets.

Executed this _____ day of _____, 20_____ for the Applicant at: _____
City and State

By: _____ Signature: _____
(please print – name and title)

Accepted for Dentegra Insurance Company
This _____ day of _____, _____
Authorization _____ initials

_____
Anthony S. Barth, Vice Chairman, Dentegra Insurance Company

Agent Information Are you appointed with Dentegra Insurance Company? ☐ yes ☐ no

Agent Name _____ TIN or SS# _____ State license # _____
(if applicable)

Signature _____ Telephone # _____

Address _____
(Street) (City) (State) (zip) (County)

ENROLLMENT/CHANGE FORM – TN

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]
[CM1]dentegra.com

Pediatric
☐ Children's Plan 70
☐ Children's Plan 85

Supplemental + Pediatric
☐ Children's Plan 70 + Adult Basic
☐ Children's Plan 85 + Adult Preferred
☐ Children's Plan 70 + Adult Preferred
☐ Children's Plan 85 + Adult Basic

Enrollee/Change Information			
☐ New Enrollment ☐ Add/Delete Dependent	☐ Marital Status Change ☐ Address Change	☐ Terminate Enrollee Coverage ☐ Other _____	☐ SSN/Enrollee ID Number Correction or Previous ID under which benefits are received _____

Primary Enrollee Information				
Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married
First Name	Last Name			MI
Mailing Address 1 (Street)				
Mailing Address 2				
Mailing Address 3	City		State	ZIP Code
Email Address (internal use only)	Phone Number		Phone Type ☐ Cell ☐ Work ☐ Home	
Name of Other Dental Carrier	Policy Holder Name (first/last)		Date of Birth	
Effective Date of Other Policy	Policy Holder Street Address	City	State	ZIP Code

Dependent Information					
Spouse/Partner	Last Name	First Name	MI	☐ Add ☐ Term	☐ Disabled*
	Social Security Number	Date of Birth	☐ Male ☐ Female		
Dependent age 19 to 26	Last Name	First Name	MI	☐ Add ☐ Term	☐ Disabled*
	Social Security Number	Date of Birth	☐ Male ☐ Female		
Dependent age 19 to 26	Last Name	First Name	MI	☐ Add ☐ Term	☐ Disabled*
	Social Security Number	Date of Birth	☐ Male ☐ Female		
Child	Last Name	First Name	MI	☐ Add ☐ Term	☐ Disabled*
	Social Security Number	Date of Birth	☐ Male ☐ Female		
Child	Last Name	First Name	MI	☐ Add ☐ Term	☐ Disabled*
	Social Security Number	Date of Birth	☐ Male ☐ Female		
Child	Last Name	First Name	MI	☐ Add ☐ Term	☐ Disabled*
	Social Security Number	Date of Birth	☐ Male ☐ Female		

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. *Additional documentation will be required for disabled status.

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

☐ I decline coverage at this time.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Enrollee _____ Date _____

FOR GROUP USE ONLY				
Group Number	Division	State	Effective Date	Hire Date
Name of Employer		Location	Paycode	Benefit Package

Enrollee Classification

☐ Full Time ☐ Part-Time ☐ Retired ☐ Hourly ☐ Salaried ☐ Member ☐ Classified ☐ Certified ☐ Other _ _____

COBRA (if applicable)

☐ Termination ☐ Reduction in Hours ☐ Divorce/Legal Separation ☐ Widowed/Surviving Dependent** ☐ Dependent Child No Longer Eligible**

indicate qualifying date __ _/_ _ /_ __

*If a dependent is enrolling under his/her social security number, the SSN currently enrolled under must be provided.

SERFF Tracking #:	*DDPA-129066948*	***State Tracking #:***	*H-130881*	***Company Tracking #:***	*DIC, OHCR GROUP PPO TN, FORMS AND RATES*

State:	*Tennessee*	***Filing Company:***	*Dentegra Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*DIC, OHCR Group PPO TN, forms and rates*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: %

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Dentegra Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*DDPA-129066948*	***State Tracking #:***	*H-130881*	***Company Tracking #:***	*DIC, OHCR GROUP PPO TN, FORMS AND RATES*

State:	*Tennessee*	***Filing Company:***	*Dentegra Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*DIC, OHCR Group PPO TN, forms and rates*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Actuarial Memorandum	OPGC-TN-DIC	New		Actuarial Memorandum Dentegra Out TN Pediatric PPO Small Group 2013 05 23.pdf,
2		Actuarial Memorandum	OXGC-TN-DIC	New		Actuarial Memorandum Dentegra Out TN Supplemental PPO Small Group 2013 05 23.pdf,

ACTUARIAL MEMORANDUM
Dentegra Insurance Company
State of Tennessee
May 23, 2013

Form Number OPGC-TN-DIC

1. **Scope and Purpose of Filing**
   This filing is for the above Dentegra Insurance Company (DIC) forms.

2. **Description of Benefits**

   The pediatric dental EHB are defined in Attachment A and cover essential health benefit services as defined by the state. These comply with the actuarial value requirements for the high and low EHB plans.

3. **Renewability**
   All small group dental programs are optionally renewable. Premiums are guaranteed for each 12-month contract term.

4. **Applicability**
   DIC anticipates both new issues and renewals under these forms.

5. **Morbidity**
   The proposed rates were developed using the Delta Dental Insurance Company (DDIC), NAIC #81396, rating manual, which is currently in use in numerous states. Adjustments have been made to reflect the fee schedules and area definitions associated with this filing.

6. **Mortality**
   Not applicable.

7. **Persistency**
   Loss ratios are expected to be consistent over time. As a result, there are no lapse assumptions.

8. **Expenses**

   Expenses are shown in Attachment B. Co-marketing in conjunction with a medical plan, may require a change in administrative assumptions due to division of labor between medical and dental, cost sharing, etc.

9. **Marketing Method**
   This will be sold to small groups through the Tennessee health exchange or through agents and brokers inside or outside the exchange.

10. **Underwriting**

The plans are manually rated.

11. **Premium Classes**
Gross premiums vary by plan designs illustrated in Attachment A.

12. **Issue Age Range**
Not applicable.

13. **Area Factors**
Manual rates are statewide.

14. **Premium Modalization Rules**
Not applicable since this is a new plan offering.

15. **Claim Liability and Reserves**
This reserve is projected from historical claims runoff, using a common reserving methodology.

16. **Active Life Reserves**
Not applicable since this is a new plan offering.

17. **Trend Assumptions**
The annual cost trend rate is 4%.

18. **Anticipated Loss Ratio**
The anticipated loss ratio is shown in Attachment B.

19. **Distribution of Business**
Not applicable since this is a new plan offering.

20. **Contingency and Risk Margins**
Risk margin is shown in Attachment B.

21. **Experience**
Please see Attachment C for DDIC small group experience.

22. **Lifetime Loss Ratio**
The lifetime loss ratio is equal to the anticipated loss ratio.

23. **Number of Policyholders**
Not applicable since this is a new plan offering.

24. **Proposed Effective Date**
01/01/2014.

25. Actuarial Certification

I, Thomas J. Leibowitz, FSA, MAAA, am a member of the American Academy of Actuaries, and meet the Academy Qualification Standard for rendering this Opinion.

I have reviewed the actuarial assumptions and methods on which the rates are based. I hereby certify that to the best of my knowledge and judgment, this rate filing is in compliance with the applicable laws and regulations of the state of Tennessee and complies with Actuarial Standard of Practice No. 8. The rates shown are

- Based on actuarially sound principles
- Are not inadequate, excessive or unfairly discriminatory, and
- Are reasonable in relation to the benefits provided.

Thomas J. Leibowitz, FSA, MAAA
Vice President and Chief Actuary
Dentegra Insurance Company
One First Street
San Francisco, CA 94105

Attachment A

Tennessee Small Group Pediatric Dental Benefits

PPO/PPO	Pediatric High	Pediatric Low
Diagnostic & Preventive	100%	100%
Basic Services	80%	50%
Major Services	50%	50%
Orthodontics (Medically Necessary)	50%	50%
Deductible		
Waived on D&P	yes	no
Per Person	$25	$45
Family	n/a	n/a
Annual Maximum	None	None
Othodontics Maximum (Lifetime)	None	None
Waiting Periods (Major & Ortho)	None	None
Out of Pocket Maximum (PPO dentists only)		
per child	$700	$700
per 2+ children	$1,400	$1,400
Dental Accident Benefits	NAB*	NAB*
Rates: Statewide	$32.60	$26.25

* NAB is not a benefit

Note: Covered procedures are defined in the forms

Attachment B

Tennessee Small Group Administrative Expenses (as a percent of premium)

	Pediatric High	Pediatric Low
Admin Expenses	22.50%	22.50%
Risk Margin	3.50%	1.00%
Premium Tax	2.50%	2.50%
ACA Tax	2.00%	2.00%
TPA Admin	0.00%	0.00%
Commissions	7.50%	7.50%
Total	38.00%	35.50%
Anticipated Loss Ratio **	64.92%	67.54%

** Anticipated Loss Ratio = (1 - Total) / (1 - Premium Tax - ACA Tax)

Attachment C
DDIC Small Group Experience

	CY2012
Number of Policy Holders	2,881
Number of Certificate Holders	38,308
Earned Premium	$24,525,709
Average Annual Premium	$640
Incurred Claims	$16,016,000
Number of Incurred Claims	124,033
Incurred Loss Ratio	65.3%

ACTUARIAL MEMORANDUM
Dentegra Insurance Company
State of Tennessee
May 23, 2013

Form Number OXGC-TN-DIC

1. **Scope and Purpose of Filing**
   This filing is for the above Dentegra Insurance Company (DIC) forms.

2. **Description of Benefits**
   The Supplemental dental plans are defined in Attachment A and cover standardly covered services.

3. **Renewability**
   All small group dental programs are optionally renewable. Premiums are guaranteed for each 12-month contract term.

4. **Applicability**
   DIC anticipates both new issues and renewals under these forms.

5. **Morbidity**
   The proposed rates were developed using the Delta Dental Insurance Company (DDIC), NAIC #81396, rating manual, which is currently in use in numerous states. Adjustments have been made to reflect the fee schedules and area definitions associated with this filing.

6. **Mortality**
   Not applicable.

7. **Persistency**
   Loss ratios are expected to be consistent over time. As a result, there are no lapse assumptions.

8. **Expenses**

   Expenses are shown in Attachment B. Co-marketing in conjunction with a medical plan, may require a change in administrative assumptions due to division of labor between medical and dental, cost sharing, etc.

9. **Marketing Method**
   This will be sold to small groups through the Tennessee health exchange or through agents and brokers inside or outside the exchange.

10. **Underwriting**
    The plans are manually rated.

11. **Premium Classes**
Gross premiums vary by plan designs illustrated in Attachment A.

12. **Issue Age Range**
Not applicable.

13. **Area Factors**
Manual rates are statewide.

14. **Premium Modalization Rules**
Not applicable since this is a new plan offering.

15. **Claim Liability and Reserves**
This reserve is projected from historical claims runoff, using a common reserving methodology.

16. **Active Life Reserves**
Not applicable since this is a new plan offering.

17. **Trend Assumptions**
The annual cost trend rate is 4%.

18. **Anticipated Loss Ratio**
The anticipated loss ratio is shown in Attachment B.

19. **Distribution of Business**
Not applicable since this is a new plan offering.

20. **Contingency and Risk Margins**
Risk margin is shown in Attachment B.

21. **Experience**
Please see Attachment C for DDIC small group experience.

22. **Lifetime Loss Ratio**
The lifetime loss ratio is equal to the anticipated loss ratio.

23. **Number of Policyholders**
Not applicable since this is a new plan offering.

24. **Proposed Effective Date**
01/01/2014.

25. Actuarial Certification

I, Thomas J. Leibowitz, FSA, MAAA, am a member of the American Academy of Actuaries, and meet the Academy Qualification Standard for rendering this Opinion.

I have reviewed the actuarial assumptions and methods on which the rates are based. I hereby certify that to the best of my knowledge and judgment, this rate filing is in compliance with the applicable laws and regulations of the state of Tennessee and complies with Actuarial Standard of Practice No. 8. The rates shown are

- Based on actuarially sound principles
- Are not inadequate, excessive or unfairly discriminatory, and
- Are reasonable in relation to the benefits provided.

Thomas J. Leibowitz, FSA, MAAA
Vice President and Chief Actuary
Dentegra Insurance Company
One First Street
San Francisco, CA 94105

Attachment A
Tennessee Small Group Supplemental Dental Benefits

PPO/PPO	Pediatric High	Pediatric Low	Adult Preferred	Adult Basic
Diagnostic & Preventive	100%	100%	100%	100%
Basic Services	80%	50%	80%	80%
Major Services	50%	50%	50%	0%
Orthodontics (Medically Necessary)	50%	50%	NAB*	NAB*
Deductible				
Waived on D&P	yes	no	yes	yes
Per Person	$25	$45	$50	$50
Family	n/a	n/a	$150	$150
Annual Maximum	None	None	$1,000	$1,000
Othodontics Maximum (Lifetime)	None	None	NAB*	NAB*
Waiting Periods (Major & Ortho)	None	None	12 mos	None
Out of Pocket Maximum (PPO dentists only)				
per child	$700	$700	NAB*	NAB*
per 2+ children	$1,400	$1,400	NAB*	NAB*
Dental Accident Benefits	NAB*	NAB*	100% w/ $1000 Lifetime Max	NAB*
Rates: Statewide	$32.60	$26.25	$53.73	$33.32

* NAB is not a benefit

Note: Plan combinations and covered procedures are defined in the forms

Attachment B
Tennessee Small Group Administrative Expenses (as a percent of premium)

	Pediatric High	Pediatric Low	Adult Preferred	Adult Basic
Admin Expenses	22.50%	22.50%	22.50%	22.50%
Risk Margin	3.50%	1.00%	3.50%	3.50%
Premium Tax	2.50%	2.50%	2.50%	2.50%
ACA Tax	2.00%	2.00%	2.00%	2.00%
TPA Admin	0.00%	0.00%	0.00%	0.00%
Commissions	7.50%	7.50%	7.50%	7.50%
Total	38.00%	35.50%	38.00%	38.00%
Anticipated Loss Ratio **	64.92%	67.54%	64.92%	64.92%

** Anticipated Loss Ratio = (1 - Total) / (1 - Premium Tax - ACA Tax)

Attachment C
DDIC Small Group Experience

	CY2012
Number of Policy Holders	2,881
Number of Certificate Holders	38,308
Earned Premium	$24,525,709
Average Annual Premium	$640
Incurred Claims	$16,016,000
Number of Incurred Claims	124,033
Incurred Loss Ratio	65.3%

SERFF Tracking #:	*DDPA-129066948*	***State Tracking #:***	*H-130881*	***Company Tracking #:***	*DIC, OHCR GROUP PPO TN, FORMS AND RATES*

State:	*Tennessee*	***Filing Company:***	*Dentegra Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*DIC, OHCR Group PPO TN, forms and rates*		
Project Name/Number:	*/*		

Supporting Document Schedules

Bypassed - Item:	Cover Letter Accident & Health
Bypass Reason:	Pertinent information is included in the filing description.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Description of Variables
Comments:	Statements of variability are attached for review.
Attachment(s):	OPGAtC-TN-DIC (with Comments 6-5-13).pdf OXGC-TN-DIC (with Comments 6-12-13).pdf OXGAtAhi-TN-DIC (with Comments 6-10-13).pdf OXGAtAlo-TN-DIC (with Comments 6-10-13).pdf OXGAtB-TN-DIC (with Comments 6-10-13).pdf OPGE-TN-DIC (with Comments 6-11-13).pdf OXGE-TN-DIC (with Comment 6-12-13).pdf OPGAtAhi-TN-DIC (with Comments 6-5-13).pdf OPGAtAlo-TN-DIC (with Comments 6-5-13).pdf OPGAtB-TN-DIC (with Comments 6-5-13).pdf OXGAtE-TN-DIC (with Comments 6-12-13).pdf OXGAtClo-TN-DIC (with Comments 6-10-13).pdf OXGAtChi-TN-DIC (with Comments 6-10-13).pdf
Item Status:	
Status Date:	

Bypassed - Item:	Filing Fees
Bypass Reason:	We pay associated filing domiciliary fees via EFT.
Attachment(s):	
Item Status:	
Status Date:	

SERFF Tracking #:	*DDPA-129066948*	***State Tracking #:***	*H-130881*	***Company Tracking #:***	*DIC, OHCR GROUP PPO TN, FORMS AND RATES*

State:	*Tennessee*	***Filing Company:***	*Dentegra Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*DIC, OHCR Group PPO TN, forms and rates*		
Project Name/Number:	*/*		

Satisfied - Item:	Readability Certification
Comments:	Readability Certification is attached for review.
Attachment(s):	Tennessee Readability Certification.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Third Party Authorization
Bypass Reason:	The insurance company is filing on its own behalf.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Group Rates Certification/Memo - Accident & Health
Comments:	Corresponding Group Rate Certifications are attached for review.
Attachment(s):	Group Rate Certification TN Dentegra Supplemental PPO.pdf Group Rate Certification TN Dentegra Pediatric PPO (2).pdf
Item Status:	
Status Date:	

Satisfied - Item:	Accident & Health Group Rates non-experience
Comments:	Please find Actuarial Memorandums attached for review.
Attachment(s):	Actuarial Memorandum Dentegra TN Pediatric PPO Small Group 2013 05 22.pdf Actuarial Memorandum Dentegra TN Supplemental PPO Small Group 2013 05 22.pdf
Item Status:	
Status Date:	

ATTACHMENT C
GROUP VARIABLES
[Information in this section is variable.]
for
[Contractholder[D1] Name]
[Group Number]

Effective Date:

Contract Term:

Premiums:
Monthly Amount:

[Pediatric[D2] Enrollee]	$	[XX[D3]]

Premiums are to be remitted to:

Dentegra Insurance Company
[[SF4]P.O. Box 1850
Alpharetta, GA 30023-1850]

Payment Breakdown:

Contractholder shall pay:	[XX[D5]]	%	for Pediatric Enrollees
Contractholder's employee shall pay:	[XX[D6]]	%	for Pediatric Enrollees

Contractholder may charge persons electing continued coverage pursuant to Title X of P.L. 99 as permitted by law.

Variable Form with Comments 6-5-13

OPGAtC-ST-DIC (Clean 6-5-13).docx

Main document changes and comments

Page 1: Comment [D1] **Courtney Rozear (ga24413)** **6/6/2013 3:44:00 PM**

Information will be completed for Contractholder Name, group number, effective date and Contract Term.

Page 1: Comment [D2] **Courtney Rozear (ga24413)** **6/6/2013 3:44:00 PM**

Rate tier variable to be completed as agreed upon with the Exchange.

Page 1: Comment [D3] **Courtney Rozear (ga24413)** **6/6/2013 3:44:00 PM**

Premium amount per Exchange rates.

Page 1: Comment [SF4] **Sharon Ford (ga31755)** **6/6/2013 3:44:00 PM**

The company's address is variable should it need to be updated in the future.

Page 1: Comment [D5] **Courtney Rozear (ga24413)** **6/6/2013 3:44:00 PM**

Percentage to be contributed by Contractholder.

Page 1: Comment [D6] **Courtney Rozear (ga24413)** **6/6/2013 3:44:00 PM**

Percentage to be contributed by Contractholder's employee.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

DENTEGRA® INSURANCE COMPANY
[1130[D1] Sanctuary Parkway
Suite 600
Alpharetta, Georgia 30009
(877) 280-4204]

Group Dental PPO Insurance Contract

The Contractholder named in Attachment E Group Variables ("Attachment E") applied for a group dental insurance Contract with Dentegra Insurance Company ("Dentegra") [through[DS2] the Packaged Offering with the Medical Plan Issuer ("MPI"), [insert Medical Plan Issuer name]]. This Contract is underwritten by Dentegra Insurance Company ("Dentegra") and administered by Delta Dental Insurance Company. The following terms will apply:

I. [Contractholder[DS3] will pay the MPI or its third party administrator the monthly Premium stated in this Contract.] [Contractholder[DS4] will pay Dentegra or its Third Party Administrator the monthly Premium stated in this Contract.]

II. When the Contractholder pays the first month's Premium, the term of this Contract will begin at 12:01 a.m. Standard Time, on the Effective Date listed in Attachment E. The term of this Contract will end as stated in this Contract at the end of the Contract Term at 12:00 midnight Standard Time.

III. [Contractholder will[CR5] provide each Employee with electronic access to a certificate/Evidence of Coverage booklet supplied by [Dentegra[DS6]/the MPI]. [Dentegra[DS7]/The MPI] will also furnish a hard copy to the Enrollee or Contractholder upon request]. [Contractholder[D8] will provide each Employee a certificate/Evidence of Coverage booklet supplied by [Dentegra[DS9]/the MPI]. Contractholder will also distribute to its Employees any notice from [Dentegra[DS10]/the MPI] which may affect their child's rights under this Contract.

So long as Contractholder pays the Premiums stated in Article 3, Dentegra agrees to provide the Benefits described in this Contract including Attachment A Deductibles, Maximums and Contract Benefit Levels ("Attachment A"); Attachment B Services, Limitations and Exclusions ("Attachment B"); Attachment B-1 Schedule of Covered Services and Limitations for Pediatric Benefits ("Attachment B-1"); Attachment C Deductibles, Maximums and Contract Benefit Levels For Adult Benefits ("Attachment C") and Attachment D Services, Limitations and Exclusions For Adult Benefits ("Attachment D").

Anthony S. Barth, Vice Chairman

Essential Health Benefit Plan – The Essential Health Benefit Plan ("Pediatric Benefits") provides coverage to Eligible Pediatric Enrollees who are dependent children of employees to whom Contractholder offers coverage. Such children are eligible for Benefits under this Contract from birth to age 19. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulation and as may be recognized by the Contractholder.

Supplemental Adult Group Benefit Plan – The Adult Group Benefit Plan provides coverage for Eligible Employees and/or Eligible Dependents which include the Eligible Employee's Spouse and children to age 26. [Additionally, [D11]children from birth to age 19 are covered for services not covered under Pediatric Benefits]. Dependent children of the Eligible Employee include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulations and as may be recognized by the Contractholder.

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ARTICLE 1
DEFINITIONS

Terms when capitalized in this document have defined meanings, given either in the section below or within the Contract sections.

1.01 **Accepted Fee --** the amount the attending Provider agrees to accept as payment in full for services rendered.

1.02 **Benefits** -- the amounts that Dentegra will pay for dental services under this Contract.

1.03 **Calendar Year** -- the 12 months of the year from January 1 through December 31.

1.04 **Claim Form** -- the standard form used to file a claim, request a Pre-Treatment Estimate or request Prior Authorization for medically necessary orthodontics.

1.05 **Contract** -- this agreement between Dentegra and Contractholder, including the attachments listed in Article 12.

1.06 **Contractholder –** a small group employer named in Attachment E.

1.07 **Contract Term** -- the period during which this Contract is in effect, as shown in Attachment E.

1.08 **Contract Year** – the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

1.09 **Dentegra PPO℠ Provider (Dentegra Provider)** -- a Provider who contracts with Dentegra and agrees to accept Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO dental plan.

1.10 **Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee)** -- the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Enrollees.

1.11 **Effective Date** -- the original date this Contract starts, as shown in Attachment E.

1.12 **Maximum Contract Allowance --** the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided.

- by Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee;
- by Non-Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic area.

1.13 [**Medical**[DS12] **Plan Issuer (MPI)** – the entity providing the medical plan that is issued and delivered to Contractholder with this dental plan as a Packaged Offering.]

1.14 **Non-Dentegra Provider --** a Provider who is not a Dentegra Provider and has not agreed to accept the Dentegra Provider's Contracted Fees.

1.15 **Open Enrollment Period** – the period of the year the [employer[DS13]/MPI] has established during which employees may change coverage selections for the next Contract Year.

1.16 [**Packaged**[DS14] **Offering** – the selection of a separate medical plan provided by the MPI bundled with this dental plan provided by Dentegra.]

1.17 **Premium** -- the amounts payable by the Contractholder monthly as provided in Attachment E.

1.18 **Pre-Treatment Estimate** -- an estimation of the allowable Benefits under this Contract for the services proposed, assuming the person is an eligible Enrollee.

1.19 **Procedure Code** – the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

1.20 **Program Allowance** -- the amount determined for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

1.21 **Provider** -- a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

1.22 **Qualifying Status Change** -- a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);

- employment status (change in employment status of employee);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee, dependent spouse or child moves);
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125

1.23 **Single Procedure** -- a dental procedure that is assigned a separate Procedure Code.

1.24 **Submitted Fee** -- the amount that the Provider bills and enters on a claim for a specific procedure.

ARTICLE 2
CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

2.01 Dentegra will pay Benefits for dental services described in Attachments B and D when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and exclusions will be applied for the period the person enrolled under any Dentegra program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional waiting periods, if any, are shown in Attachments A and C.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

2.02 Dentegra's provision of Benefits is limited to the applicable portion of the Provider's fees or allowances specified in Attachments A and C for Diagnostic and Preventive, Basic, Major, and Medically Necessary Orthodontic Services. The Enrollee is responsible for paying the balance of any fees or allowances known as "Coinsurance". Contractholder has chosen to require Coinsurances under this program as a method of sharing the costs of providing dental Benefits between Contractholder and Enrollees. If the Provider discounts, waives or rebates any portion of the Coinsurance to the Enrollee, Dentegra will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of such Coinsurance fees or allowances that are discounted, waived or rebated.

2.03 **Deductible**
Dentegra will not pay Benefits for services received each Calendar Year by an Enrollee until the Deductible, as shown in Attachments A and C, has been satisfied. The annual Deductible per family, if any, is shown in Attachments A and C. Only fees an Enrollee pays for covered services will count toward the Deductible.

2.04 **Maximum**.
A maximum amount ("Maximum Amount" or "Maximum") is the maximum dollar amount Dentegra will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. Dentegra will pay the Maximum Amount(s), if applicable, shown in Attachments A and C for Benefits under this Contract.

2.05 **Coordination of Benefits**
Dentegra coordinates the Benefits under this Contract with an Enrollee's benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. If this Contract is the "primary" plan, Dentegra will not reduce Benefits. If this is the "secondary" plan, Dentegra may reduce Benefits otherwise payable under this Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

Order of Benefit Determination Rules:
The following rules determine which plan is the "primary" plan:
(1) The plan covering the Enrollee as an employee is primary over a plan covering the Enrollee as a dependent.
(2) The plan covering the Enrollee as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    a) Secondary to the plan covering the insured person as a dependent and
    b) Primary to the plan covering the insured person as other than a dependent (e.g. a retired employee),
    then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
(3) Except as stated in paragraph (4), when this plan and another plan cover the same child as a dependent of different persons, called parents:
    a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but

b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.
(5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).
(6) The benefits of a plan which covers an insured person as an employee who is neither laid-off nor retired are determined before those of a plan which covers that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (6) is ignored.
(7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
a) First, the benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);
b) Second, the benefits under the continuation coverage.
If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
(8) If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the plan which covered that insured person for the shorter term.
(9) When determination cannot be made in accordance with the above for Pediatric Benefits, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

2.06 **Clinical Examination**
Before approving a claim, Dentegra may obtain, to such extent as may be lawful, from any Provider, or from hospitals in which a Provider's care is provided, such information and records relating to an Enrollee as Dentegra may require to administer the claim. Dentegra, at its own expense, may also require that an Enrollee be examined by a dental consultant retained by Dentegra, as often as necessary, in or near his/her community or residence while a claim is pending. Such information and records will be kept confidential in accordance with all applicable laws and regulations.

2.07 **Notice of Claim Forms**
Dentegra will furnish to any Provider or Enrollee, on request, a Claim Form to make a claim for payment of Benefits. To make a claim, the Claim Form must be completed and signed by the Provider who performed the services and by the Enrollee (or the parent or guardian of a minor) and submitted to Dentegra at the address shown thereon. If Dentegra does not furnish the form within 15 days after requested by a Provider or Enrollee, the requirements for proof of loss set forth in section 2.09 of this Contract will be deemed to have been complied with upon the submission to Dentegra within the time established in said section for filing proof of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. Enrollees may download a Claim Form from Dentegra's website.

2.08 **Prior Authorization for Medically Necessary Orthodontics**
Orthodontic treatment is covered under Pediatric Benefits, which are shown in Attachments A, B and B-1, only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

2.09 **Pre-Treatment Estimates**
A Provider may file a Claim Form before treatment, showing the services to be provided to an Enrollee. Dentegra will estimate the amount of Benefits payable under this Contract for the listed services. Benefits will be processed according to the terms of this Contract when the treatment is performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date this Contract terminates;
- the date Benefits under this Contract are amended if services in the Pre-Treatment Estimate are part of the amendment;
- the date the Enrollee's coverage ends; or
- the date the Provider's agreement with Dentegra ends.

2.10 **Written Notice of Claim/Proof of Loss**
Dentegra must be given a written notice of claim, sometimes referred to as a written proof of loss, within 12 months after the date of the loss and must include information regarding other group coverage if applicable. If it is not

reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one (1) year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to Dentegra within 12 months of the termination of this Contract.

2.11 **Time of Payment**
Claims payable under this Contract for any loss other than for which this Contract provides any periodic payment will be paid no later than 30 days after written proof of loss is received. Dentegra will notify the Primary Enrollee and his/her Provider of any additional information needed to process the claim within this 30 day period.

2.12 **Claims Appeal**
Dentegra will notify the Enrollee and his/her Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Enrollee has at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to Dentegra giving reasons why they believe the denial was wrong. The Enrollee and his/her Provider may also ask Dentegra to examine any additional information provided that may support the appeal or grievance.

Send appeal or grievance to Dentegra at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Dentegra will send the Enrollee a written acknowledgment within five (5) days upon receipt of the appeal or grievance. Dentegra will make a full and fair review within 30 days after Dentegra receives the complaint, grievance or appeal. Dentegra may ask for more documents if needed. Dentegra will send the Enrollee a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of this Contract, Dentegra shall consult with a Dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. Dentegra will send Enrollee a decision within 30 days after receipt of the Enrollee's appeal [or grievance].

If the Enrollee believes he/she needs further review of their appeal or grievance, he/she may contact his/her state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action under Section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

2.13 **To Whom Benefits Are Paid**
Payment for services provided by a Dentegra Provider will be made directly to the Provider. Any other payments provided by this Contract will be made to the Primary Enrollee unless Enrollee requests when filing proof of loss that the payment be made directly to the Provider providing the services. All Benefits not paid to the Provider will be payable to the Primary Enrollee, to his/her estate, or to an alternate recipient as directed by court order except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

2.14 No change in Benefits will become effective during a Contract Term unless Contractholder and Dentegra agree in writing.

ARTICLE 3
REPORTING AND MONTHLY PREMIUMS

3.01 **Reporting**
Dentegra processes eligibility as reported by the [Contractholder[DS15]/MPI].

Contractholder is responsible for notifying [Dentegra[DS16]/the MPI] with additions, changes or terminations made during the prior month as required by [Dentegra[DS17]/the MPI]. An Enrollee remains enrolled until the Contractholder notifies [Dentegra[DS18]/the MPI] of the termination. If the Enrollee loses coverage or makes any change that affects eligibility, Contractholder must promptly notify [Dentegra[DS19]/the MPI] of such change.

Dentegra will not make any payment for services provided to an Enrollee who is not reported to Dentegra as eligible under this Contract when the service is provided. Also, Dentegra may not pay Benefits for an Enrollee if Premiums are not paid for the month in which dental services are rendered. Dentegra shall not be obligated to recover claims paid to a Provider as a result of Contractholder's retroactive eligibility adjustments. The Contractholder agrees to reimburse

Dentegra for any erroneous claim payments made by Dentegra as a result of incorrect eligibility reporting by the Contractholder to [Dentegra[DS20]/the MPI].

Retroactive[DS21] premium adjustments are limited to the immediately preceding three (3) months plus the current billing month.

3.02 Contractholder will permit Dentegra to audit Contractholder's records to confirm compliance with Article 3, 7 and 10. Dentegra will give Contractholder written notice within a reasonable time before the audit date.

3.03 [Contractholder [D22]will remit to the MPI or its third party administrator the Premium in the amount and manner shown in Attachment E for all Enrollees.] [Contractholder [D23]will remit to Dentegra or its Third Party Administrator the Premium in the amount and manner shown in Attachment E for all Enrollees.]

For[DS24] enrollment additions, Contractholder will remit a full month's Premium for Enrollees whose coverage is effective on the first through the fifteenth calendar day of a month. Premiums are not due to Dentegra for Enrollees who are enrolled on the sixteenth through the last day of a month.]

For[DS25] enrollment terminations, Contractholder will remit a full month's Premium for Enrollees whose coverage is terminated on the sixteenth through the last calendar day of a respective month. Premiums are not due to Dentegra for Enrollees whose enrollment is terminated on the first through the fifteenth day of a month.]

3.04 This Contract will not be in effect until Dentegra receives the first month's Premiums. Subsequent Premiums will be paid by the first day of each month. For each Premium after the first, a grace period of 31 days from the due date will be allowed for the payment of the Premium. This Contract will continue in force during this period; if the Premium remains unpaid at the end of the grace period, this Contract may be terminated by Dentegra in accordance with the notice requirements of section 4.01. Any payment received after 90 days of the due date shall be subject to interest charges at an annualized rate equal to one percentage point above the then current three (3) month U.S. Treasury Bill rate, which interest shall commence accruing as of the first day following the end of the 31 day grace period.

3.05 If this Contract is terminated before the end of a Contract Term, Contractholder will pay additional charges in accordance with Article 4.

3.06 Dentegra will not be responsible or liable for any incorrect, incomplete, obsolete or unreadable data or information supplied to Dentegra including, but not limited to, eligibility and enrollment information.

3.07 Dentegra may change the monthly Premium whenever this Contract is amended as stated in section 3.08, or whenever the Contractholder requests a change in Benefits, eligibility or when due to a state and/or federal mandated change. Any change in Premium shall not be effective during a Contract Term unless Contractholder and Dentegra agree in writing, except as provided in section 3.08 or a state and/or federal mandated change.

3.08 If during the Contract Term any new or increased tax, assessment, or fee is imposed on the amounts payable to, or by, Dentegra under this Contract or any immediately preceding contract between Dentegra and Contractholder, the Premium amount stated in Attachment E will be increased by the amount of any such new or increased tax, assessment, or fee by written notice to Contractholder, and this Contract shall thereby be modified on the date set forth in the notice.

ARTICLE 4
TERMINATION AND RENEWAL

4.01 This Contract may be terminated only as follows:

- By Dentegra upon 31 days written notice if Contractholder fails to pay Premiums, in the amount and manner required by Article 3.
- By Contractholder or Dentegra at the end of a Contract Term upon 60 days written notice.
- [By[DS26] Dentegra as of the termination date of the bundled medical plan as notified by the MPI.]

4.02 In the event this Contract is terminated under section 4.01 first bullet item, Contractholder will become immediately obligated upon termination to pay Dentegra for that portion of the monthly Premium which constitutes for the current Contract Term Dentegra's direct costs of administering this Contract (calculated by subtracting the pure Premium from the total Premium) multiplied by the remaining number of months from the date of termination to the expiration of the current Contract Term, but the amount will not exceed 25 percent of the total Premium for the entire Contract Term.

4.03 If Dentegra is notified that the Contractholder intends to terminate this Contract upon less than 60 days notice, Section 4.02 will apply as if Dentegra terminated this Contract under section 4.01 first bullet.

4.04 Dentegra will not be required to do Pre-Treatment Estimates if this Contract is terminated for any cause nor will Dentegra be required to pay for services performed beyond the termination date except for completion of Single Procedures commenced while this Contract was in effect as stated in section 7.04 and 10.05.

4.05 [Contractholder[DS27] will receive renewal information from the MPI prior to any applicable Open Enrollment Period. Provided Dentegra continues to make this policy available through the MPI at the renewal period, Contractholder may elect to continue to offer this Contract to Eligible Enrollees, subject to the applicable Premium available through the MPI for this plan at the time of renewal.]

[Dentegra[DS28] will provide [60][d29] days advance written renewal notice prior to the end of the initial or any subsequent Contract Terms indicating if Premiums and/or Benefits will remain the same or change. The Contractholder's payment of the Premium indicated in the renewal notice for the new Contract Term will signify the Contractholder's acceptance of the renewal. If the Contractholder fails to provide written notification to Dentegra of non-renewal by the date indicated in the renewal letter and/or does not pay the Premiums indicated in the renewal notice with the new Contract Term, Dentegra will terminate this Contract under section 4.01 first bullet.]

ARTICLE 5
GENERAL PROVISIONS

5.01 **Entire Contract: Changes**
This Contract, including the attachments listed in Article 12, is the entire agreement between the parties. No agent has authority to change this Contract or waive any of its provisions. No change in this Contract will be valid unless approved by an executive officer of Dentegra.

5.02 **Severability**
If any part of this Contract or an amendment of it is found by a court or other authority to be illegal, void or not enforceable, all other portions of this Contract will remain in full force and effect.

5.03 **Conformity With State Laws**
All legal questions about this Contract will be governed by the state of Tennessee where this Contract was entered into and is to be performed. Any part of this Contract which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

5.04 **Misstatements on Application; Effect**
In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of this Contract, all statements made by the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under this Contract, unless it is contained in a written instrument signed by the Contractholder, a copy of which has been furnished to such Contractholder.

5.05 **Legal Actions**
No action at law or in equity will be brought to recover on this Contract before 60 days after written proof of loss has been furnished in accordance with requirements of this Contract; nor will an action be brought after the expiration of three (3) years after the time written proof is required to be furnished.

5.06 **Not in Lieu of Workers' Compensation**
This Contract is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

5.07 **Certificate of Insurance**
[[Dentegra[CR30]/MPI] will issue to the Contractholder an electronic file containing a certificate/EOC summarizing the Benefits to which Enrollees are entitled and to whom Benefits are payable. Each Eligible Employee enrolled under this Contract will have electronic access to the certificate.[[Dentegra[DS31]/The MPI] will also furnish a hard copy to an Enrollee or the Contractholder upon request]. [[Dentegra[D32]/The MPI] will issue to the Contractholder for delivery to each Eligible Employee enrolled under this Contract a certificate/EOC booklet summarizing the Benefits to which they are entitled and to whom Benefits are payable]. The certificate is not assignable and the Benefits are not assignable prior to a claim. If any amendment to this Contract will materially affect any Benefits described in the certificate, new certificates or amendments showing the change will be issued.

5.08 **Publications About Program**
Contractholder and Dentegra agree to consult as is reasonably practical on all material published or distributed about this Contract. No material will be published or distributed which conflicts with the terms of this Contract.

5.09 **Provider Relationship**
Contractholder and Dentegra agree to permit and encourage the professional relationship between Provider and Enrollee to be maintained without interference. Any Dentegra or Non-Dentegra Provider, including any Provider or employee associated with or employed by them, who provides dental services to Enrollees does so as an independent contractor and shall be solely responsible for dental advise and for performance of dental services, or lack thereof, to the Enrollee.

5.10 **Notice; Where Directed**
All formal notice under this Contract must be in writing and sent by email, facsimile (fax), first-class United States mail, overnight delivery service, or personal delivery. Notice by United States mail will be effective 48 hours after mailing with fully prepaid postage.

Contractholder shall designate in writing a representative for purposes of receiving notices from Dentegra under this Contract. Contractholder may change its representative at any time with 30 days written notice to Dentegra. The Contractholder's representative shall disseminate notices to the Enrollees within 30 days of receipt.

5.11 **Indemnification**
Contractholder will indemnify, defend and hold harmless Dentegra, its directors, officers, employees, agents and affiliated companies against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Contractholder's negligent performance or non-performance of its obligations under this Agreement.

Dentegra will indemnify, defend and hold harmless Contractholder and its employees and agents, against any and all claims, demands, liabilities, costs, damages and causes of action or administrative proceedings whatsoever, including reasonable attorney's fees, arising from Dentegra's negligent performance or non-performance of its obligations under this Agreement.

5.12 **Time Limit On Certain Defenses**
After this Contract has been in force for three (3) years from the Effective Date, no statement made by the Contractholder will be used to void this Contract. No statement by an Enrollee with respect to the Enrollee's insurability, will be used to reduce or deny a claim or contest the validity of insurance for such Enrollee after that person's coverage has been in effect three (3) years or more during his or her lifetime.

5.13 **Compliance with Administrative Simplification, Security and Privacy Regulations**
Contractholder and Dentegra shall comply in all respects with applicable federal, state and local laws and regulations relating to administrative simplification, security and privacy of individually identifiable Enrollee information including executing a Business Associate Addendum as required by Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Contractholder and Dentegra agree that this Contract shall incorporate terms as necessary and as applicable to execute the required agreements (i.e. business associate agreement) to comply with federal regulations issued under the HIPAA, HITECH Act or to comply with any other enacted administrative simplifications, security or privacy laws or regulations.

5.14 **Impossibility of Performance**
Neither party shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires, or unusually severe weather. Dates and times of performance shall be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

5.15 **Third Party Administrator ("TPA")**
Dentegra may use the services of a TPA, duly registered under applicable state law, to provide services under this Contract. Any TPA providing such services or receiving such information shall enter into a separate Business Associate Agreement with Dentegra providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

5.16 **Mutual Confidentiality**
Contractholder and Dentegra agree to maintain confidential information using the same degree of care (which shall be no less than reasonable care) as each uses to protect its own confidential information of a similar nature and to use confidential information only for specified purposes. Confidential information includes any information which the owner deems confidential, whether marked as confidential or otherwise clearly identifiable as confidential and includes information not generally known by the public or by parties which are competitive with or otherwise in an industry, trade or business similar to the owner of the confidential information. The recipient of confidential information shall notify the owner of any unauthorized disclosure or breach of confidentiality as soon as possible after discovery and without unreasonable delay.

5.17 **Trademarks; Service Marks**
Unless specifically allowed in this Contract, neither party shall use the name, trademarks, service marks or other proprietary branding of the other party without the advance written approval of the other party.

ARTICLE 6
ADDITIONAL DEFINITIONS FOR PEDIATRIC BENEFITS

Terms when capitalized in this document have defined meanings, given either in the section below or within the Contract sections.

6.01 **Contract Benefit Level** -- the percentage of the Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment A.

6.02 **Deductible** -- a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits as shown in Attachment A.

6.03 **Eligible Pediatric Enrollee** – a person eligible for Benefits under Article 7.

6.04 **Employee** – an individual employed by the Contractholder and who has opted to cover his/her child(ren) under this Contract.

6.05 **Out-of-Pocket Maximum** – the maximum amount a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from a Non-Dentegra Provider even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

6.06 **Patient Pays** – the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

6.07 **Pediatric Enrollee** – an Eligible Pediatric Enrollee enrolled to receive Benefits; may also be referred to as "Enrollee".

6.08 **Pediatric Enrollee's Effective Date of Coverage** – the date the [Contractholder[DS33]/MPI] reports coverage will begin for each Pediatric Enrollee.

ARTICLE 7
ELIGIBILITY AND ENROLLMENT FOR PEDIATRIC BENEFITS

7.01 **Eligible Pediatric Enrollee**
Eligible Pediatric Enrollees are dependent children of Employees to whom Contractholder offers coverage. Such dependent children are eligible for Benefits under this Contract from birth to age 26.

Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulations and as may be recognized by the Contractholder.

Pediatric Enrollees on active military duty are not eligible.

7.02 **Enrollment of Eligible Pediatric Enrollees**
The [Contractholder[DS34]/MPI] is responsible for establishing the Pediatric Enrollee's Effective Date of Coverage for enrollment. Eligible Pediatric Enrollees must be enrolled within [31[d35]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS36] Pediatric Enrollees who enroll in the Contractholder's medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

7.03 Except for an Employee absent from work due to a leave of absence governed by the "Family & Medical Leave Act of 1993" (P.L. 103.3), a Pediatric Enrollee will not be covered for any dental services received while an Employee is on strike, lay-off or leave of absence. Contractholder must inform the [Dentegra[DS37]/MPI] of any change in eligibility as required under section 3.01.

Coverage will resume the first day of the month after the Employee returns to work, provided the Contractholder submits the request to [Dentegra[DS38]/the MPI] that coverage be reactivated.

Benefits for such Pediatric Enrollee will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and Out-of-Pocket Maximums for the Pediatric Enrollee will resume as if the Employee was never gone.
- If coverage is reactivated in a different Calendar Year, new Deductibles and Out-of-Pocket Maximums will apply.

If an Employee is rehired within the same Calendar Year, Deductibles and Out-of-Pocket Maximums will resume as if the Employee was never gone.

7.04 Coverage will terminate when a Pediatric Enrollee loses dependent status or reaches age 26.

Termination of Benefits on Loss of Eligibility
Dentegra will not pay for Benefits for any services received by a person who is not a Pediatric Enrollee at the time of treatment except for covered dental services incurred when the person was covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

7.05 **Continuation of Coverage Under COBRA**
When the employees of a Contractholder are covered under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), then in consideration of the payments specified in Article 3, Dentegra agrees to provide Benefits to Pediatric Enrollees for whom continued coverage is elected pursuant to this section, provided:

- continuation of coverage is required to be offered under COBRA;
- the Pediatric Enrollee requests the continuation within the time frame allowed;
- the Contractholder notifies [Dentegra[DS39]/the MPI] that the Pediatric Enrollee has elected to continue coverage under COBRA;
- Dentegra receives the required Premium for the continued coverage;
- this Contract stays in force.

Dentegra does not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

ARTICLE 8
CHOICE OF PROVIDERS FOR PEDIATRIC BENEFITS

8.01 Pediatric Enrollees may choose a Provider from Dentegra's panel of PPO Providers or Pediatric Enrollees may choose a Non-Dentegra Provider. A list of Providers can be obtained by accessing the Dentegra Provider directory at dentegra.com. A representative can provide specific Provider information over the phone or by mail. Pediatric Enrollees are responsible for verifying whether the selected Provider is a Dentegra Provider. Additionally, Pediatric Enrollees should always confirm with the Provider's office that a listed Provider is still a participating Dentegra Provider. Dentegra does not guarantee that any particular Provider will be available.

Dentegra Provider
Selecting a Dentegra Provider potentially allows the greatest reduction in Pediatric Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon. Also, the services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A.

Non-Dentegra Provider
If a Provider is a Non-Dentegra Provider, the amount charged to Pediatric Enrollees may be above that accepted by the Dentegra Providers, and Pediatric Enrollees will still be responsible for Coinsurance and other cost-sharing, including balance billed amounts, after the Out-of-Pocket Maximum is met. Costs incurred by the patient with a Non-Dentegra Provider do not count towards the Out-of-Pocket Maximum. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

Additional advantages of using a Dentegra Provider:

- The Dentegra Provider must accept assignment of Benefits, meaning Dentegra Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Pediatric Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra Provider's Contracted Fee.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

ARTICLE 9
ADDITIONAL DEFINITIONS FOR ADULT BENEFITS

Terms when capitalized in this document have defined meanings, given either in the section below or within the Contract sections.

9.01 **Contract Benefit Level** -- the percentage of the Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment C.

9.02 **Deductible** -- a dollar amount that an Enrollee and/or the Dependent Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits as shown in Attachment C.

9.03 **Dependent Enrollee** -- an Eligible Dependent enrolled to receive Benefits; may also be referred to as "Enrollee".

9.04 **Eligible Dependent** -- a dependent of an Eligible Employee eligible for Benefits under Article 10.

9.05 **Eligible Employee** -- any employee eligible for Benefits under Article 10.

9.06 **Enrollee's Effective Date of Coverage** -- the date the [Contractholder[DS40]/MPI] reports coverage will begin for each Enrollee.

9.07 **Patient Pays** -- Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

9.08 **Primary Enrollee--** an Eligible Employee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee".

9.09 **Spouse** -- a person related to or a partner of the Eligible Employee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where this Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Eligible Employee resides; and
- as may be recognized by the Contractholder.

ARTICLE 10
ELIGIBILITY AND ENROLLMENT FOR ADULT BENEFITS

10.01 **Eligible Employees**
Eligible Employees are employees of Contractholder to whom Contractholder offers coverage.

10.02 **Eligible Dependents**
Eligible Dependents are the Spouse and children to age 26. [Additionally[DS41], children from birth to age 19 are covered for services not covered under Pediatric Benefits]. Dependent children of the Eligible Employee include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by the applicable state regulations and as may be recognized by the Contractholder.

A dependent unmarried child 26 years of age or older may continue eligibility if:

1) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
2) he or she is chiefly dependent on the Eligible Employee or Spouse for support; and
3) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Eligible Employee or Spouse for support because of a mental or physical disability that began before he or she reached the limiting age.

Dependents on active military duty are not eligible.

10.03 **Enrollment of Eligible Employees and/or Dependent Enrollees**
The [Contractholder[DS42]/MPI] is responsible for establishing the Enrollee's Effective Date of Coverage for enrollment. Eligible Enrollees must be enrolled within [31[d43]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS44] Employees and/or Dependent Enrollees who enroll in the Contractholder's medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

10.04 Except for an employee absent from work due to a leave of absence governed by the "Family & Medical Leave Act of 1993" (P.L. 103.3), an Enrollee will not be covered for any dental services received while an Eligible Employee is on strike, lay-off or leave of absence. Contractholder must inform [Dentegra[DS45]/the MPI] of any change in eligibility as required under section 3.01.

Coverage will resume the first day of the month after the employee returns to work, provided the Contractholder submits the request to [Dentegra[DS46]/the MPI] that coverage be reactivated.

Benefits for such will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and maximums will resume as if the Eligible Employee were never gone.
- If coverage is reactivated in a different Calendar Year, new Deductibles and maximums will apply.

If an employee is rehired within the same Calendar Year, Deductibles and maximums will resume as if the Eligible Employee was never gone.

10.05 *Termination of Benefits on Loss of Eligibility*
Dentegra will not pay for Benefits for any services received by a person who is not an Enrollee at the time of treatment except for covered dental services incurred when the person was covered if such procedure is completed within 31 days of the date coverage ends. A dental service is incurred as follows:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

10.06 **Continued Coverage Under USERRA**
As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if a Primary Enrollee is covered by this Contract on the date his or her USERRA leave of absence begins, the Primary Enrollee may continue dental coverage for himself or herself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of: 24 months beginning on the date the leave of absence begins or the date the Primary Enrollee fails to return to work within the time required by USERRA. For USERRA leave that extends beyond 31 days, the Premium for continuation of coverage will be the same as for COBRA coverage.

10.07 **Continuation of Coverage Under COBRA**
When the Eligible Employees of a Contractholder are covered under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), then in consideration of the payments specified in Article 3, Dentegra agrees to provide the Benefits to Enrollees who elect continued coverage pursuant to this section, provided:

- Continuation of coverage is required to be offered under COBRA;
- The Enrollee requests the continuation within the time frame allowed;
- The Contractholder notifies [Dentegra[DS47]/the MPI] that the Enrollee has elected to continue coverage under COBRA;
- Dentegra receives the required Premium for the continued coverage;
- This Contract stays in force.

Dentegra does not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA).

ARTICLE 11
CHOICE OF PROVIDERS FOR ADULT BENEFITS

11.01 Enrollees may choose a Provider from Dentegra's panel of PPO Providers or Enrollees may choose a Non-Dentegra Provider. A list of Dentegra Providers can be obtained at Dentegra's website (dentegra.com). Providers are regularly added to or deleted from the list. Enrollees are responsible for verifying whether the selected Provider is a PPO Provider. Additionally, Enrollees should always confirm with the Provider's office that a listed Provider is still a participating Dentegra Provider.

Dentegra Provider
Selecting a Dentegra Provider potentially allows the greatest reduction in Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon.

Non-Dentegra Provider
If a Provider is a Non-Dentegra Provider, the amount charged to Enrollees may be above that accepted by the Dentegra Providers. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

Additional Obligations of Dentegra Provider:

- The Dentegra Provider must accept assignment of Benefits, meaning Dentegra Providers will be paid directly by Dentegra after satisfaction of the Deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra Provider's Contracted Fee.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

ARTICLE 12
ATTACHMENTS

These documents are attached to this Contract and made a part of it:

Attachment A **Deductibles, Maximums and Contract Benefit Levels For Pediatric Benefits**
Attachment B **Services, Limitations and Exclusions For Pediatric Benefits**
Attachment B-1 **Schedule of Covered Services For Pediatric Benefits**
Attachment C **Deductibles, Maximums and Contract Benefit Levels For Adult Benefits**
Attachment D **Services, Limitations and Exclusions For Adult Benefits**
Attachment E **Group Variables**

Variable Form with Comments 6-12-13

OXGC-TN-DIC (Clean 6-12-13).docx (Last saved by user)

Main document changes and comments

Page 1: Comment [D1] **Courtney Rozear (ga24413)** **5/7/2013 3:08:00 AM**

The company's address and phone number are shown as variable throughout this document should they need to be updated in the future.

Page 1: Comment [DS2] **Debbie Shealy (ga62861)** **5/7/2013 12:38:00 PM**

Use the variable for bundled arrangements; otherwise delete.

Page 1: Comment [DS3] **Debbie Shealy (ga62861)** **5/7/2013 12:31:00 PM**

Language used if MPI if billing, collecting premium and forwarding to Dentegra or its third party administrator; otherwise delete.

Page 1: Comment [DS4] **Debbie Shealy (ga62861)** **5/7/2013 12:31:00 PM**

Use if stand-alone – no MPI; otherwise delete.

Page 1: Comment [CR5] **Connie Roth (ga23784)** **3/25/2013 12:42:00 PM**

Standard is for electronic EOCs to be provided. Delete if hard copies are required.

Page 1: Comment [DS6] **Debbie Shealy (ga62861)** **5/7/2013 4:51:00 PM**

Select Dentegra or MPI depending on who is responsible for EOC delivery.

Page 1: Comment [DS7] **Debbie Shealy (ga62861)** **5/7/2013 4:51:00 PM**

Select Dentegra or MPI depending on who is responsible for EOC delivery.

Page 1: Comment [D8] **Courtney Rozear (ga24413)** **3/25/2013 12:44:00 PM**

Standard is to issue an electronic file use this if hard copies are required, this sentence would be used and sentences associated with CR3 would be deleted.

Page 1: Comment [DS9] **Debbie Shealy (ga62861)** **5/7/2013 4:52:00 PM**

Select Dentegra or MPI depending on who is responsible for EOC delivery.

Page 1: Comment [DS10] **Debbie Shealy (ga62861)** **5/7/2013 4:55:00 PM**

Select Dentegra or MPI depending on who is responsible for EOC delivery.

Page 1: Comment [D11] **Courtney Rozear (ga24413)** **5/7/2013 4:57:00 PM**

This variable is not standard and used only with underwriting approval.

Page 3: Comment [DS12] **Debbie Shealy (ga62861)** **5/7/2013 1:08:00 PM**

Include only if bundled; otherwise delete and renumber.

Page 3: Comment [DS13] **Debbie Shealy (ga62861)** **5/7/2013 12:50:00 PM**

Select employer if not bundled and MPI if bundled.

Page 3: Comment [DS14] **Debbie Shealy (ga62861)** **5/7/2013 3:35:00 PM**

Include only if bundled; otherwise delete and renumber.

Page 6: Comment [DS15] **Debbie Shealy (ga62861)** **5/7/2013 5:00:00 PM**

Select entity that is responsible for eligibility.

Page 6: Comment [DS16] **Debbie Shealy (ga62861)** **5/7/2013 5:00:00 PM**

Select entity that is responsible for eligibility.

Page 6: Comment [DS17] **Debbie Shealy (ga62861)** **5/7/2013 5:01:00 PM**

Select entity that is responsible for eligibility.

Page 6: Comment [DS18] **Debbie Shealy (ga62861)** **5/7/2013 5:01:00 PM**

Select entity that is responsible for eligibility.

Page 6: Comment [DS19] **Debbie Shealy (ga62861)** **5/7/2013 5:01:00 PM**

Variable Form with Comments 6-12-13

Select entity that is responsible for eligibility.

Page 7: Comment [DS20] **Debbie Shealy (ga62861)** **5/7/2013 5:01:00 PM**

Select entity that is responsible for eligibility.

Page 7: Comment [DS21] **Debbie Shealy (ga62861)** **5/7/2013 5:24:00 PM**

Include if Dentegra responsible for billing and collection of premium; delete if MPI responsible.

Page 7: Comment [D22] **Eboni Warren (ga28462)** **5/7/2013 12:59:00 PM**

Use if MPI billing, collecting premium and forwarding to us; otherwise delete.

Page 7: Comment [D23] **Eboni Warren (ga28462)** **5/7/2013 11:23:00 AM**

Use if Dentegra billing and collecting premium; otherwise delete.

Page 7: Comment [DS24] **Debbie Shealy (ga62861)** **5/7/2013 5:24:00 PM**

Include if Dentegra responsible for billing and collection of premium; delete if MPI responsible.

Page 7: Comment [DS25] **Debbie Shealy (ga62861)** **5/7/2013 5:25:00 PM**

Include if Dentegra responsible for billing and collection of premium; delete if MPI responsible.

Page 7: Comment [DS26] **Debbie Shealy (ga62861)** **5/7/2013 1:16:00 PM**

Include if bundled; otherwise delete.

Page 8: Comment [DS27] **Debbie Shealy (ga62861)** **5/7/2013 2:05:00 PM**

Include if bundled; otherwise delete.

Page 8: Comment [DS28] **Debbie Shealy (ga62861)** **6/13/2013 4:56:00 PM**

Include if not bundled; otherwise delete.

Page 8: Comment [d29] **dpcwr5** **5/7/2013 2:11:00 PM**

60 days is standard but may change if requested by Contractholder and approved by Underwriting.

Page 8: Comment [CR30] **Connie Roth (ga23784)** **5/7/2013 5:03:00 PM**

Standard option; however, if printed certificates are negotiated delete this option. Select entity responsible for delivery.

Page 8: Comment [DS31] **Debbie Shealy (ga62861)** **5/7/2013 5:03:00 PM**

Select entity responsible for EOC delivery.

Page 8: Comment [D32] **Courtney Rozear (ga24413)** **6/13/2013 4:56:00 PM**

Standard is to issue an electronic, if printed is required include this sentence; otherwise, delete. Select entity responsible for EOC delivery.

Page 10: Comment [DS33] **Debbie Shealy (ga62861)** **5/7/2013 2:39:00 PM**

Select Contractholder or MPI depending on who is responsible for eligibility reporting.

Page 10: Comment [DS34] **Debbie Shealy (ga62861)** **5/7/2013 2:50:00 PM**

Select Contractholder or MPI depending on who is responsible for eligibility reporting.

Page 10: Comment [d35] **Courtney Rozear (ga24413)** **5/7/2013 2:45:00 PM**

The time to enroll may be increased at the Contractholder's request with Underwriting approval up to 180 days.

Page 10: Comment [DS36] **Debbie Shealy (ga62861)** **5/7/2013 5:44:00 PM**

Include if bundled with MPI otherwise delete.

Page 10: Comment [DS37] **Debbie Shealy (ga62861)** **5/7/2013 2:47:00 PM**

Select Dentegra or MPI depending on who is responsible for eligibility.

Page 10: Comment [DS38] **Debbie Shealy (ga62861)** **5/7/2013 2:48:00 PM**

Select Dentegra or MPI depending on who is responsible for eligibility.

Page 11: Comment [DS39] **Debbie Shealy (ga62861)** **5/7/2013 2:52:00 PM**

Variable Form with Comments 6-12-13

Select Dentegra or MPI depending on who is responsible for eligibility.

Page 12: Comment [DS40] **Debbie Shealy (ga62861)** **5/7/2013 2:53:00 PM**

Select Contractholder or MPI depending on who is responsible for eligibility.

Page 12: Comment [DS41] **Debbie Shealy (ga62861)** **5/7/2013 3:11:00 PM**

This variable is not standard and used only with underwriting approval.

Page 12: Comment [DS42] **Debbie Shealy (ga62861)** **5/7/2013 3:17:00 PM**

Select Contractholder or MPI depending on who is responsible for eligibility reporting.

Page 12: Comment [d43] **Courtney Rozear (ga24413)** **5/7/2013 3:17:00 PM**

The time to enroll may be increased at the Contractholder's request with Underwriting approval up to 180 days.

Page 12: Comment [DS44] **Debbie Shealy (ga62861)** **5/7/2013 5:45:00 PM**

Include if bundled with MPI otherwise delete.

Page 12: Comment [DS45] **Debbie Shealy (ga62861)** **5/7/2013 3:22:00 PM**

Select Contractholder or MPI depending on who is responsible for eligibility reporting.

Page 12: Comment [DS46] **Debbie Shealy (ga62861)** **5/7/2013 3:26:00 PM**

Select Contractholder or the MPI depending on who is responsible for eligibility reporting.

Page 13: Comment [DS47] **Debbie Shealy (ga62861)** **5/7/2013 3:28:00 PM**

Select Dentegra or the MPI depending on who is responsible for eligibility.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

Attachment A
Deductibles, Maximums and Contract Benefit Levels for Pediatric Benefits
Dentegra Dental PPO
Children's Plan 85

Deductibles & Maximums	
Annual Deductible	$25 per Pediatric Enrollee each Calendar Year The annual Deductible is waived for Diagnostic and Preventive Services.
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Pediatric Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers*	
Individual	$700 each Calendar Year
Multiple Child	$1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount a Pediatric Enrollee must satisfy for covered dental services under the Contract during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If an Employee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO Providers†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Medically Necessary Orthodontic Services (requires Prior Authorization)	50%	50%

†Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

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Main document changes and comments

Page 1: Comment [D1] **Courtney Rozear (ga24413)** **2/4/2013 12:27:00 AM**

Include Deductible Takeover if Contractholder has prior group coverage and Effective Date is other than January 1st.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

Attachment A
Deductibles, Maximums and Contract Benefit Levels for Pediatric Benefits
Dentegra Dental PPO
Children's Plan 70

Deductibles & Maximums	
Annual Deductible	$45 per Pediatric Enrollee each Calendar Year
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Pediatric Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers*	
Individual	$700 each Calendar Year
Multiple Child	$1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount a Pediatric Enrollee must satisfy for covered dental services under the Contract during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If an Employee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO Providers†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	50%	50%
Major Services	50%	50%
Medically Necessary Orthodontic Services (requires Prior Authorization)	50%	50%

†Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

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Main document changes and comments

Page 1: Comment [D1] **Courtney Rozear (ga24413)** **2/4/2013 12:27:00 AM**

Include Deductible Takeover if Contractholder has prior group coverage and Effective Date is other than January 1st.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

Attachment B
Services, Limitations and Exclusions for Pediatric Benefits
Dentegra PPO
Children's Plan [85/70[D1]]

Description of Dental Services

Dentegra will pay or otherwise discharge the Contract Benefit Level shown in Attachment A for the services shown on Attachment B-1 when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthdontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a Prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

Limitations

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Dentegra will pay for oral examinations (except exams for observation) no more than twice in a Calendar Year. Only one (1) comprehensive evaluation is allowed in a Calendar Year and counts toward the oral examination frequency in the year provided. One (1) limited oral evaluation, problem-focused no more than once in a Calendar Year.

(5) X-ray limitations:

a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(6) Dentegra will pay for routine cleanings and topical application of fluoride solutions no more than twice in a Calendar Year, and periodontal cleanings in the presence of inflamed gums up to four (4) times in a Calendar Year. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings not to exceed four (4) procedures or any combination thereof in a Calendar Year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

(7) Space maintainer limitations:

a) Space maintainers are limited to the initial appliance.
b) Recementation of space maintainer is limited to once per lifetime.

c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(8) Sealants are limited as follows:
a) to permanent molars through age 18 if they are without caries (decay) or restorations on the occlusal surface.
b) do not include repair or replacement of a Sealant on any tooth within 36 months of its application.

(9) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.

(10) Dentegra will not cover to replace an amalgam or resin-based composite within 24 months of treatment if the service is provided by the same Provider/Provider office. Pefabricated stainless steel crowns are limited to once per Enrollee per tooth per lifetime. Replacement restorations within 24 months are included in the fee for the original restoration.

(11) Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 15.

(12) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only. It is a benefit for primary incisor teeth up to age six (6) and for primary molars and cuspids to age 11.

(13) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(14) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Retrograde fillings per root are limited to once in any 24-month period.

(17) Pin retention is covered not more than once in any 24-month period.

(18) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(19) Period ontal limitations:
a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
b) Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
f) One crown lengthening per tooth per lifetime.

(20) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(21) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(22) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any 60 month period.

(23) Core buildup, including any pins, are covered not more than once in any 60 month period.

(24) Post and core services are covered not more than once in any 60 month year period.

(25) Crown repairs are covered not more than once in any 60 month period.

(26) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(27) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(28) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Removable cast base partial dentures are limited to Enrollees age 12 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.

(29) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(30) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a (6) month period by the same Provider/Provider office.

(31) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Contractholder's prior plan, if applicable

(32) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments and relining are limited to one (1) per arch in a 36-month period.
   c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
   d) Recementation of fixed partial dentures is limited to once in a lifetime.

(33) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period.

(34) Athletic mouth guards are limited to one (1) per 12 consecutive month period.

(35) Internal bleaching of discolored teeth shall not be provided for any tooth more than once each 36 months while the patient is an Enrollee under any Dentegra plan.

Exclusions

Dentegra does not pay Benefits for:

(1) services not included on Attachment B-1 Schedule of Covered Services except medically necessary Orthodontics provided a Prior Authorization is obtained.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) maxillofacial prosthetics.

(5) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).

(6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.

(8) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(10) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures if such procedures included in Attachment B-1.

(11) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(12) laboratory processed crowns for Enrollees under age 12.

(13) fixed bridges and removable partials for Enrollees under age 16.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) overdentures.

(16) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(17) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(18) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(19) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(20) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(21) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(22) Deductibles and/or any service not covered under the dental plan.

(23) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(24) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan with Dentegra or the Contractholder's prior dental plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(25) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(26) endodontic endosseous implant.

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Main document changes and comments

Page 1: Comment [D1] **Eboni Warren (ga28462)** **4/23/2013 2:20:00 PM**

Insert the applicable plan number at time of issue.

Header and footer changes

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Footnote changes

Endnote changes

[logo[D1]]

Dentegra® Dental PPO

Children's [Plan 70/Plan 85[D2]]

Group Name[DR3]

Group No.[DR4]

Effective Date[DR5]

[Revised][DR6]

Provided by:

Dentegra Insurance Company

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[dentegra[D7].com]

[MPI website and phone number[D8]]

Table of Contents

Attachments

INTRODUCTION

Your employer has chosen Dentegra® Insurance Company ("Dentegra") to meet your dental insurance needs. This plan is underwritten by Dentegra and administered by Delta Dental Insurance Company. Our goal is to provide the Pediatric Enrollees with the highest quality dental care and to help him/her maintain good dental health. We encourage Pediatric Enrollees not to wait until there is a problem to see the Provider, but to see him/her on a regular basis.

Using This Evidence of Coverage - This Evidence of Coverage booklet, which includes Attachment A Deductibles, Maximums and Contract Benefit Levels ("Attachment A") and Attachment B Services, Limitations and Exclusions ("Attachment B") and Attachment B-1 Schedule of Covered Services and Limitations ("Attachment B-1"), discloses the terms and conditions of Pediatric Enrollee's coverage and is designed to help he/she make the most of their dental plan. It will help the Employee and/or the Pediatric Enrollee understand how the plan works and how the Pediatric Enrollee may obtain dental care. Please read this booklet completely and carefully. Keep in mind that "you" and "your" mean the Enrollees who are covered. "We," "us" and "our" always refer to Dentegra. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Contract.

The benefit explanations contained in this booklet are subject to all provisions of the Contract on file with the employer ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Notice: *This booklet is a summary of your group dental program and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.*

Contact Us

For more information please visit our website at[D9] [dentegra.com] or call our Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at [877-280-4204] [D10]to obtain information about your eligibility, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850][D11]

Anthony S. Barth, Vice Chairman

DEFINITIONS

Terms when capitalized in this Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits: the amounts that Dentegra will pay for dental services under the Contract.

Calendar Year: the 12 months of the year from January 1 through December 31.

Claim Form: the standard form used to file a claim or request Pre-Treatment Estimate or request Prior Authorization for medically necessary orthodontics.

Contract: the agreement between Dentegra and the Contractholder, including any attachments.

Contract Benefit Level -- the percentage of the Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment A.

Contractholder: a small group employer named on this booklet's cover.

Contract Term: the period during which the Contract is in effect.

Contract Year: the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Deductible -- a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits as shown in Attachment A.

Dentegra PPO℠ Provider (Dentegra Provider): a Provider who contracts with Dentegra and agrees to accept Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO dental plan.

Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee): the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Pediatric Enrollees.

Effective Date: the original date the contract starts. This date is given on this booklet's cover.

Eligible Pediatric Enrollee: a person eligible for Benefits under the Contract.

Employee: an individual employed by the Contractholder and who has opted to cover his/her child(ren) under the Contract.

Maximum Contract Allowance: the reimbursement under the Pediatric Enrollee's benefit plan against which Dentegra calculates its payment and the financial obligation for the Pediatric Enrollee. Subject to adjustment for extreme difficulty or unusual circumstance, the Maximum Contract Allowance for services provided:

- by Dentegra Providers is the lesser of the Submitted Fee on the claim or the Dentegra Provider's Contracted Fee; or
- by Non-Dentegra Providers is the lesser of the Submitted Fee on the claim or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic area.

[**Medical**[DS12] **Plan Issuer ("MPI"):** the entity providing the medical plan that is issued and delivered to Contractholder with this dental plan as a Packaged Offering.]

Non-Dentegra Provider: a Provider who is not a Dentegra Provider and has not agreed to accept the Dentegra Provider's Contracted Fees.

Open Enrollment Period: the period of the year that the [employer[DS13]/MPI] has established during which Employees may change coverage selections for the next Contract Year.

Out-of-Pocket Maximum: the maximum amount a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including

balance billed amounts, will continue to apply for covered services from Non-Dentegra Provider even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

[**Packaged**[DS14] **Offering:** the selection of a separate medical plan provided by the MPI bundled with this dental plan provided by Dentegra.]

Patient Pays: the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

Pediatric Enrollee: an Eligible Pediatric Enrollee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee".

Pediatric Enrollee's Effective Date of Coverage: the date the [Contractholder[DS15]/MPI] reports coverage will begin for each Pediatric Enrollee.

Pre-Treatment Estimate: an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an Eligible Pediatric Enrollee.

Procedure Code: the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

Program Allowance: the amount determined for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Qualifying Status Change: a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of Employee);
- dependent child ceases to satisfy eligibility requirements;
- residence (Employee or child moves);
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

Single Procedure: a dental procedure that is assigned a separate procedure code.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

PREMIUMS:

The Employee may be required to contribute towards the cost the Pediatric Enrollee's coverage.

We may cancel the Contract 31 days after written notice to the Contractholder if monthly premiums are not paid when due.

ELIGIBILITY AND ENROLLMENT

Eligible Pediatric Enrollee

Eligible Pediatric Enrollees are dependent children of employees to whom Contractholder offers coverage. Such dependent children are eligible for Benefits under the Contract from birth to age 26.

Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by the applicable state regulations and as may be recognized by the Contractholder.

Pediatric Enrollees serving on active military duty are not eligible.

Enrollment of Eligible Pediatric Enrollees

The [Contractholder[DS16]/MPI] is responsible for establishing Pediatric Enrollee's Effective Date of Coverage for enrollment. Eligible Pediatric Enrollees must be enrolled within [31[d17]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS18] Pediatric Enrollees who enroll in the Contractholder's medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

Coverage will terminate when a Pediatric Enrollee loses dependent status or reaches age 26.

Continuation of Benefits

We will not pay for any services/treatment received after the Pediatric Enrollee's coverage ends. However, we will pay for covered services incurred while he/she were eligible if the procedures were completed within 31 days of the date his/her coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence

Pediatric Enrollees will not be covered for any dental services received while the Employee is on strike, lay-off, leave of absence, other than as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Coverage will resume the first day of the month after the Employee returns to work, provided the Contractholder submits the requests to [Dentegra[D19]/the MPI] that coverage be reactivated.

Benefits for Pediatric Enrollees will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and Out-of-Pocket Maximums will resume for the Pediatric Enrollee as if the Employee was never gone.
- If coverage is reactivated in a different Calendar Year, new Deductibles and Out-of-Pocket Maximums will apply.
- If an Employee is rehired within the same Calendar Year, Deductibles and Out-of-Pocket Maximums for the Pediatric Enrollee will resume as if the Employee was never gone.

*Coverage for Pediatric Enrollees is not affected if the Employee takes a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If the Employee is currently paying any part of the premium, he/she may choose to continue coverage. If the Employee does not continue coverage

during the leave, he/she can resume coverage for Pediatric Enrollees on their return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act does not apply to all companies, only those that meet certain size guidelines. See the Human Resources Department for complete information.

Continuation of Coverage Under COBRA
COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for the Pediatric Enrollee who loses employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA.

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

We will pay Benefits for the types of dental services described in Attachment B and Attachment B-1. We will pay Benefits only for covered services. The Contract covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and exclusions will be applied for the period the person is an Enrollee under any Dentegra program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional waiting periods, if any, are listed in Attachment A.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services as shown in Attachment A, and the balance is the financial obligation for the Pediatric Enrollee. The balance is called the coinsurance (“Coinsurance”) and is part of his/her out-of-pocket cost. Coinsurance is paid even after a Deductible has been met.

The amount of Coinsurance will depend on the type of service and the Provider providing the service (see section titled “Selecting Your Provider”). Providers are required to collect Coinsurance for covered services. The Employee’s group has chosen to require Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Pediatric Enrollees. If the Provider discounts, waives or rebates any portion of the Coinsurance, we will be obligated to provide as Benefits only the applicable percentages of the Provider’s fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to the Pediatric Enrollee’s advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for him/her. Please refer to the sections titled “Selecting Your Provider” and “How Claims Are Paid” for more information.

Deductible

A Deductible is an amount that must paid on behalf of the Pediatric Enrollee before Benefits are paid. The Deductible amounts, if any, are listed in Attachment A. Deductibles apply to all benefits unless otherwise noted. Only fees paid for covered Benefits will count toward the Deductible.

Prior Authorization for Medically Necessary Orthodontics

Orthodontic treatment is covered only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization ("Prior Authorization") is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, the Pediatric Enrollee's Provider may file a Claim Form before beginning treatment, showing the services to be provided to the Pediatric Enrollee. We will estimate the amount of Benefits payable under the Contract for the listed services. By asking his/her Provider for a Pre-Treatment Estimate from us before the Pediatric Enrollee receives any prescribed treatment, we will provide an estimate up front of what we will pay and the difference is the financial obligation of the Pediatric Enrollee. The Benefits will be processed according to the terms of the Contract when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date Benefits under the Contract are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date the Pediatric Enrollee's coverage ends; or
- the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if the Pediatric Enrollee is enrolled and meets all the requirements of the program at the time the treatment planned is completed and may not take into account any Deductibles, so please remember to figure in the Pediatric Enrollee's Deductible if necessary.

Coordination of Benefits

We coordinate the Benefits under the Contract with the Pediatric Enrollee's benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. If this plan is the "primary" plan, we will not reduce Benefits. If this plan is the "secondary" plan, we may reduce Benefits otherwise payable under the Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

- How do we determine which Plan is the "primary" plan?
  (1) Except as stated in paragraph (2), when this plan and another plan cover the same child as a dependent of different persons, called parents:
    a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but
    b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
    c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
  (2) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.
  (3) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (1) under the first bullet.

(4) When determination cannot be made in accordance with the above, the benefits of the plan which covered the Pediatric Enrollee longer are determined before those of the plan which has covered the Pediatric Enrollee for the shorter term.

(5) When determination cannot be made in accordance with the above, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

SELECTING YOUR PROVIDER

Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support the right to freedom of choice regarding the Pediatric Enrollee's Provider. Freedom of choice assures that the Pediatric Enrollee has full access to the dental treatment they need from the dental office of his/her choice. The Pediatric Enrollee may see any Provider for his/her covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider. In addition, family members can see different Providers.

Remember, Pediatric Enrollees enjoy the greatest Benefits—including out-of-pocket savings—when they choose a Dentegra Provider. To take full advantage of the dental plan, we highly recommend the Pediatric Enrollee verify a dentist's participation status within a Dentegra network with his/her dental office before each appointment. Review the section titled "How Claims Are Paid" for an explanation of Dentegra payment procedures to understand the method of payments applicable to his/her Dentist selection and how that may impact his/her out-of-pocket costs.

Locating a Dentegra Provider

There are two ways in which the Pediatric Enrollee can locate a Dentegra Provider in his/her area:

- Pediatric Enrollees may access information through our website at [dentegra.com]. This website includes a Provider search function allowing the Pediatric Enrollee to locate Dentegra Providers by location, specialty and network type; or
- Pediatric Enrollees may also call our Customer Service Center toll-free at [877-280-4204] and one of our representatives will assist them. We can provide the Pediatric Enrollee with information regarding a Provider's network, specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — Dentegra Provider

Payment for covered services performed for the Pediatric Enrollee by a Dentegra Provider is calculated based on the Maximum Contract Allowance. The services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A. Dentegra Providers have agreed to accept the Dentegra Provider's Contracted Fee as the full charge for covered services.

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A. Dentegra's payment is sent directly to the Dentegra Provider who submitted the claim. We advise the Pediatric Enrollee of any charges not payable by us for which they are responsible. These charges are generally the Pediatric Enrollee's share of the Maximum Contract Allowance, as well as any Deductibles and/or charges for non-covered services.

Payment for Services — Non-Dentegra Provider

Payment for services performed for the Pediatric Enrollee by a Non-Dentegra Provider is also calculated based on the Maximum Contract Allowance. The amount charged to the Pediatric Enrollee may be above that accepted by the Dentegra Providers and Pediatric Enrollees will still be responsible for Coinsurance and other cost-sharing, including balance billed amounts, after the Out-of-Pocket Maximum is met. Costs incurred by the Pediatric Enrollee with a Non-Dentegra Provider do not count towards the Out-of-Pocket Maximum. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in

Attachment A. Non-Dentegra Providers have no agreement with Dentegra and are free to bill the Pediatric Enrollee for any difference between what Dentegra pays and the Submitted Fee.

When dental services are received from a Non-Dentegra Provider, Dentegra's payment is sent directly to the Pediatric Enrollee , unless he/she has assigned the Benefits to the Provider. The Pediatric Enrollee is responsible for payment of the Non-Dentegra Provider's Submitted Fee. Non-Dentegra Providers will bill the Pediatric Enrollee for his/her normal charges, which may be higher than the Maximum Contract Allowance for the service. The Pediatric Enrollee may be required to pay the Provider and then submit a claim to us for reimbursement. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in Attachment A. Since our payment for services the Pediatric Enrollee receives may be less than the Non-Dentegra Provider's actual charges, the out-of-pocket cost may be significantly higher. We advise the Pediatric Enrollees of any charges not payable by us for which the Pediatric Enrollee is responsible. These charges are generally his/her share of the Maximum Contract Allowance, as well as any Deductibles and/or charges for non-covered services.

How to Submit a Claim

Dentegra does not require special Claim Forms. However, most dental offices have Claim Forms available. Dentegra Providers will fill out and submit the Pediatric Enrollee's claims paperwork. Some Non-Dentegra Providers may also provide this service upon request. If the Pediatric Enrollee receives services from a Non-Dentegra Provider who does not provide this service, the claim can be submitted directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

The Pediatric Enrollee's dental office should be able to assist him/her in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

CLAIMS APPEALS

We will notify the Pediatric Enrollee and his/her Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. The Pediatric Enrollee and his/her Provider have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why he/she believe the denial was wrong. The Pediatric Enrollee may also ask us to examine any additional information that may support the appeal or grievance.

Send appeal or grievance to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1809]

We will send the Pediatric Enrollee a written acknowledgment within five (5) days upon receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, we shall consult with a Dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. We will send the Pediatric Enrollee a decision within 30 days after receipt of the Pediatric Enrollee's appeal [or grievance].

If the Pediatric Enrollee believes further review is needed of their appeal [or grievance], he/she may contact the state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Pediatric Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if the Pediatric Enrollee has questions about the rights under ERISA. The Pediatric Enrollee may also bring a civil action under Section 502(a) of

ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GENERAL PROVISIONS

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to the Pediatric Enrollee as may be required to administer the claim, or have the Pediatric Enrollee examined by a dental consultant retained by us at our own expense, in or near his/her community or a residence. We will in every case hold such information and records confidential.

Notice of Claim Form

We will give the Pediatric Enrollee or his/her Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by us within 15 days after requested by the Pediatric Enrollee or his/her Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. The Pediatric Enrollee or his/her Provider may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss

We must be given written proof of loss within 12 months after the date of the loss and must include information regarding other group coverage if applicable. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to us within 12 months of the termination of the Contract.

Time of Payment

Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. We will notify the Pediatric Enrollee and his/her Provider of any additional information needed to process the claim within this 30 day period.

To Whom Benefits Are Paid

It is not required that the service be provided by a specific Dentist. Payment for services provided by a Dentegra Provider will be made directly to the Dentist. Any other payments provided by the Contract will be made to the Pediatric Enrollee , unless he/she requests when filing a proof of claim that the payment be made directly to the dentist providing the services. All Benefits not paid to the Provider will be payable to the Pediatric Enrollee, or to his/her estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all statements made by the Employee or the Pediatric Enrollee or the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under the Contract, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement made with intent to deceive which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same Premium rate. If any misstatement would materially affect the

rates, we reserve the right to adjust the Premium to reflect the Pediatric Enrollee's actual circumstances at enrollment.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the Contract, nor will an action be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Conformity With Prevailing Laws

All legal questions about the Contract will be governed by the state of Tennessee where the Contract was entered into and is to be performed. Any part of the Contract which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

EMPLOYEE NOTICE

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
(2) the insurer was not authorized to do business in this state;
(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) any policy of reinsurance (unless an assumption certificate was issued);
(3) interest rate yields that exceed an average rate;
(4) dividends;
(5) credits given in connection with the administration of a policy by a group contract holder;
(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association 150 3rd Avenue South, Suite 1600 Nashville, TN 37201

Tennessee Department of Commerce and Insurance 500 James Robertson Parkway Nashville,Tennessee 37243

NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to tell you how Dentegra protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate. These affiliates have also implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.
  For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.
- Uses and/or disclosures of PHI for payment.
  For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.
- Uses and/or disclosures of PHI for health care operations.
  For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.

Disclosures Without an Authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Disclosures Dentegra Makes With Your Authorization

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

Your Rights Regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the Dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your Dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by email. You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

Contact

You may contact the Privacy Department at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Phone: [877-280-4204]

This notice is effective on and after August 1, 2012

[logo[D1]]

Dentegra® Dental PPO

Children's [Plan 70/85[D2]] + Adult [Basic/Preferred[D3]]

Group Name[DR4]

Group No.[DR5]

Effective Date[DR6]

[Revised][DR7]

Provided by:

Dentegra Insurance Company

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[dentegra[D8].com]
[MPI website and phone number[D9]]

Table of Contents

Attachments

Variable Form with Comments 6-12-13

INTRODUCTION

Your employer has chosen Dentegra® Insurance Company ("Dentegra") to meet your dental insurance needs. This plan is underwritten by Dentegra and administered by Delta Dental Insurance Company. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Provider, but to see him/her on a regular basis.

Essential Health Benefit Plan - The Essential Health Benefit Plan ("Pediatric Benefits") provides coverage to Eligible Pediatric Enrollees who are dependent children of employees to whom Contractholder offers coverage. Such children are eligible for Benefits under the Contract from birth to age 26. Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulation and as may be recognized by the Contractholder.

Supplemental Adult Group Benefit Plan - The Adult Group Benefit Plan provides coverage for Eligible Employees and/or Eligible Dependents which include the Eligible Employee's Spouse and children from age 19 to age 26. [Additionally, [D10]children from birth to age 19 are covered for services not covered under Pediatric Benefits.] Dependent children of the Eligible Employee include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by applicable state regulations and as may be recognized by the Contractholder.

Using This Evidence of Coverage - This Evidence of Coverage booklet, which includes Attachment A Deductibles, Maximums and Contract Benefit Levels ("Attachment A") , Attachment B Services, Limitations and Exclusions ("Attachment B"); Attachment B-1 Schedule of Covered Services and Limitations for Pediatric Benefits ("Attachment B-1"); Attachment C Deductibles, Maximums and Contract Benefit Levels for Adult Benefits ("Attachment C") and Attachment D Services, Limitations and Exclusions for Adult Benefits ("Attachment D"), discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. "We," "us" and "our" always refer to Dentegra. In addition, please read the Definitions section, which will explain any words that have special or technical meanings under the Contract.

The benefit explanations contained in this booklet are subject to all provisions of the Contract on file with your employer ("Contractholder") and do not modify the terms and conditions of the Contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Notice: *This booklet is a summary of your group dental program and its accuracy should be verified before receiving treatment. This information is not a guarantee of covered benefits, services or payments.*

Contact Us

For more information please visit our website at[D11] [dentegra.com] or call our Customer Service Center. A Customer Service Representative can answer questions you may have about obtaining dental care, help you locate a Dentegra Provider, explain Benefits, check the status of a claim, and assist you in filing a claim.

You can access our automated information line at [877-280-4204] [D12]to obtain information about Enrollee eligibility and Benefits, group benefits, or claim status, or to speak to a Customer Service Representative for assistance. If you prefer to write us with your question(s), please mail your inquiry to the following address:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850][D13]

Anthony S. Barth, Vice Chairman

DEFINITIONS

Terms when capitalized in your Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Accepted Fee: the amount the attending Provider agrees to accept as payment in full for services rendered.

Benefits: the amounts that Dentegra will pay for dental services under the Contract.

Calendar Year: the 12 months of the year from January 1 through December 31.

Claim Form: the standard form used to file a claim, request a Pre-Treatment Estimate or request Prior Authorization for medically necessary orthodontics .

Contract: the agreement between Dentegra and the Contractholder, including any attachments.

Contractholder: a small group employer named on this booklet's cover.

Contract Term: the period during which the Contract is in effect.

Contract Year: the 12 months starting on the Effective Date and each subsequent 12 month period thereafter.

Dentegra PPO℠ Provider (Dentegra Provider): a Provider who contracts with Dentegra and agrees to accept Dentegra Provider's Contracted Fees as payment in full for services provided under this PPO dental plan.

Dentegra PPO Provider's Contracted Fee (Dentegra Provider's Contracted Fee): the fee for each Single Procedure that Dentegra Providers have contractually agreed to accept as payment in full for treating Enrollees.

Effective Date: the original date the contract starts. This date is given on this booklet's cover.

Maximum Contract Allowance: the reimbursement under the Enrollee's benefit plan against which Dentegra calculates its payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstance, the Maximum Contract Allowance for services provided:

- by Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee; or
- by Non-Dentegra Providers is the lesser of the Submitted Fee or the Dentegra Provider's Contracted Fee for a Dentegra Provider in the same geographic area.

[**Medical**[DS14] **Plan Issuer ("MPI"):** the entity providing the medical plan that is issued and delivered to Contractholder with this dental plan as a Packaged Offering.]

Non-Dentegra Provider: a Provider who is not a Dentegra Provider and has not agreed to accept the Dentegra Provider's Contracted Fees.

Open Enrollment Period: the period of the year that the [employer[DS15]/MPI] has established during which Eligible Employees may change coverage selections for the next Contract Year.

[**Packaged**[DS16] **Offering:** the selection of a separate medical plan provided by the MPI bundled with this dental plan provided by Dentegra.]

Pre-Treatment Estimate: an estimation of the allowable Benefits under the Contract for the services proposed, assuming the person is an eligible Enrollee.

Procedure Code: the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

Program Allowance: the amount determined for a set percentile level of all charges for such services by Providers with similar professional standing in the same geographical area. Program Allowances may differ based on the Provider's contracting status.

Provider: a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Qualifying Status Change: a change in:

- marital status (marriage, divorce, legal separation, annulment or death);
- number of dependents (a child's birth, adoption of a child, placement of child for adoption, addition of a step or foster child or death of a child);
- employment status (change in employment status of employee);
- dependent child ceases to satisfy eligibility requirements;
- residence (Enrollee, Spouse or child moves);
- a court order requiring dependent coverage;
- loss of minimal essential coverage; or
- any other current or future election changes permitted by Internal Revenue Code Section 125.

Single Procedure: a dental procedure that is assigned a separate procedure code.

Submitted Fee: the amount that the Provider bills and enters on a claim for a specific procedure.

PREMIUMS:

You may be required to contribute towards the cost of coverage for yourself, Pediatric Enrollees and Dependent Enrollees.

We may cancel the Contract 31 days after written notice to the Contractholder if monthly premiums are not paid when due.

CONDITIONS UNDER WHICH BENEFITS ARE PROVIDED

We will pay Benefits for the dental services described in Attachments B and D. We will pay Benefits only for covered services. The Contract covers several categories of dental services when a Provider provides them and when they are necessary and within the standards of generally accepted dental practice standards. Claims shall be processed in accordance with our standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. Limitations and exclusions will be applied for the period the person is an Enrollee under any Dentegra program or prior dental care program provided by the Contractholder subject to receipt of such information from the Contractholder or at the time a claim is submitted. Additional waiting periods, if any, are listed in Attachments A and C.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable under the Contract. Even if the Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

Coinsurance

We will pay a percentage of the Maximum Contract Allowance for covered services as shown in Attachments A and C, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Coinsurance") and is part of your out-of-pocket cost. You pay this even after a Deductible has been met.

The amount of Coinsurance will depend on the type of service and the Provider providing the service (see section titled "Selecting Your Provider"). Providers are required to collect Coinsurance for covered services. Eligible Employee's group has chosen to require Coinsurances under this program as a method of sharing the costs of providing dental Benefits between the Contractholder and Enrollees. If the Provider discounts, waives

or rebates any portion of the Coinsurance, we will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

It is to your advantage to select Dentegra Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to the sections titled "Selecting Your Provider" and "How Claims Are Paid" for more information.

Deductible

Your dental plan features a Deductible. This is an amount you must pay out-of-pocket before Benefits are paid. The Deductible amounts, if any, are listed in Attachments A and C. Deductibles apply to all benefits unless otherwise noted. Only the Provider's fees you pay for covered benefits will count toward the Deductible.

Maximum Amount

A maximum amount ("Maximum Amount" or "Maximum") is the maximum dollar amount we will pay toward the cost of dental care. Enrollees must satisfy costs above this amount. We will pay the Maximum Amount(s), if applicable, shown in Attachments A and C for Benefits under the Contract.

Prior Authorization for Medically Necessary Orthodontics

Orthodontic treatment is covered under Pediatric Benefits, which are shown in Attachments A, B and B-1, only when medically necessary as evidenced by a severe handicapping malocclusion, and prior authorization ("Prior Authorization") is required. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

Pre-Treatment Estimates

Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under the Contract for the listed services. By asking your Provider for a Pre-Treatment Estimate from us before you agree to receive any prescribed treatment, you will have an estimate up front of what we will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the Contract when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days, or until an earlier occurrence of any one of the following events:

- the date the Contract terminates;
- the date Benefits under the Contract are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage ends; or
- the date the Provider's agreement with Dentegra ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount we will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

Coordination of Benefits

We coordinate the Benefits under the Contract with your benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other policies. If this plan is the "primary" plan, we will not reduce Benefits. If this plan is the "secondary" plan, we may reduce Benefits otherwise payable under the Contract so that the total benefits paid or provided by all plans do not exceed 100 percent of total allowable expense.

How do we determine which Plan is the "primary" plan?

(1) The plan covering the Enrollee as an employee is primary over a plan covering the Enrollee as a dependent.

(2) The plan covering the Enrollee as an employee is primary over a plan which covers the insured person as a dependent; except that: if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

a) Secondary to the plan covering the insured person as a dependent and

b) Primary to the plan covering the insured person as other than a dependent (e.g. a retired employee),

then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.

(3) Except as stated in paragraph (4), when this plan and another plan cover the same child as a dependent of different persons, called parents:

a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year, but

b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody, or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy which covers the child as a dependent child.

(5) If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).

(6) The benefits of a plan which covers an insured person as an employee who is neither laid-off nor retired are determined before those of a plan which covers that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (6) is ignored.

(7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:

a) First, the benefits of a plan covering the insured person as an employee or Primary Enrollee (or as that insured person's dependent);

b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(8) If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the plan which covered that insured person for the shorter term.

(9) When determination cannot be made in accordance with the above for Pediatric Benefits, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental-only plan.

SELECTING YOUR PROVIDER

Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support the right to freedom of choice regarding your Provider. Freedom of choice assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any Provider for your covered treatment, whether the Provider is a Dentegra Provider or a Non-Dentegra Provider. In addition, family members can see different Providers.

Remember, you enjoy the greatest Benefits—including out-of-pocket savings—when you choose a Dentegra Provider. To take full advantage of your Benefits, we highly recommend you verify a dentist's participation status within a Dentegra network with your dental office before each appointment. Review the sections titled "How Claims Are Paid", "Choice of Provider for Pediatric Benefits" and "Choice of Provider for Adult Benefits" for an explanation of Dentegra payment procedures to understand the method of payments applicable to your Dentist selection and how that may impact your out-of-pocket costs.

Locating a Dentegra Provider

There are two ways in which you can locate a Dentegra Provider near you:

- You may access information through our website at [dentegra.com]. This website includes a Provider search function allowing you to locate Dentegra Providers by location, specialty and network type; or
- You may also call our Customer Service Center toll-free at [877-280-4204] and one of our representatives will assist you. We can provide you with information regarding a Provider's network, specialty and office location.

HOW CLAIMS ARE PAID

Payment for Services — Dentegra Provider

Payment for covered services performed for you by a Dentegra Provider is calculated based on the Maximum Contract Allowance Dentegra Providers have agreed to accept the Dentegra Provider's Contracted Fee as the full charge for covered services..

The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in the Attachments A and C. Dentegra's payment is sent directly to the Dentegra Provider who submitted the claim. We advise you of any charges not payable by us for which you are responsible. These charges are generally your share of the Maximum Contract Allowance, as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

Payment for Services — Non-Dentegra Provider

Payment for services performed for you by a Non-Dentegra Provider is also calculated based on the Maximum Contract Allowance. The portion of the Maximum Contract Allowance payable by us is limited to the applicable Contract Benefit Level shown in the Attachments A and C. Non-Dentegra Providers have no agreement with Dentegra and are free to balance bill you for any difference between what Dentegra pays and the Submitted Fee.

When dental services are received from a Non-Dentegra Provider, Dentegra's payment is sent directly to the Primary Enrollee, unless you have assigned the Benefits to the Provider. You are responsible for payment of the Non-Dentegra Provider's Submitted Fee. Non-Dentegra Providers will bill you for their normal charges, which may be higher than the Maximum Contract Allowance for the service. You may be required to pay the Provider and then submit a claim to us for reimbursement. Since our payment for services you receive may be less than the Non-Dentegra Provider's actual charges, your out-of-pocket cost may be significantly higher. We advise you of any Coinsurance as well as any Deductibles, charges where the maximum has been exceeded, and/or charges for non-covered services.

How to Submit a Claim

Dentegra does not require special Claim Forms. However, most dental offices have Claim Forms available. Dentegra Providers will fill out and submit your claims paperwork. Some Non-Dentegra Providers may also provide this service upon your request. If you receive services from a Non-Dentegra Provider who does not provide this service, you can submit your own claim directly to us. Please refer to the section titled "Notice of Claim Form" for more information.

Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

CLAIMS APPEALS

We will notify you and your Provider if Benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You and your Provider have at least 180 days after receiving a notice of denial to request an appeal or grievance by writing to us giving reasons why you believe the denial was wrong. You may also ask us to examine any additional information you include that may support the appeal or grievance.

Send appeal or grievance to us at the address shown below:

Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1809]

We will send you a written acknowledgment within five (5) days upon receipt of the appeal or grievance. We will make a full and fair review and may ask for more documents if needed. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, we shall consult with a Dentist who has appropriate training and experience. The review will be conducted for us by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. We will send you a decision within 30 days after receipt of your appeal or grievance.

If the Enrollee believe he/she needs further review of their appeal or grievance, he/she may contact his/her state regulatory agency if applicable. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), he/she may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if he/she has questions about the rights under ERISA. He or she may also bring a civil action under Section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration (EBSA), 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GENERAL PROVISIONS

Clinical Examination

Before approving a claim, we will be entitled to receive, to such extent as may be lawful, from any attending or examining Provider, or from hospitals in which a Provider's care is provided, such information and records relating to attendance to or examination of, or treatment provided to you as may be required to administer the claim. Dentegra, at its own expense, has the right to have an Enrollee examined by a dental consultant retained by us, as often as necessary, in or near your community or a residence, while a claim is pending. We will in every case hold such information and records confidential.

Notice of Claim Form
We will give you or your Provider, on request, a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services and by the patient (or the parent or guardian if the patient is a minor) and submitted to us at the address above.

If the form is not furnished by us within 15 days after requested by you or your Provider, the requirements for proof of loss set forth in the next paragraph will be deemed to have been complied with upon the submission to us, within the time established in said paragraph for filing proofs of loss, of written proof covering the occurrence, the character and the extent of the loss for which claim is made. You may download a Claim Form from our website.

Written Notice of Claim/Proof of Loss
We must be given written proof of loss within 12 months after the date of the loss and must include information regarding other group coverage if applicable. If it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, provided proof is filed as soon as reasonably possible. In any event, proof of loss must be given no later than one year from such time (unless the claimant was legally incapacitated).

All written proof of loss must be given to us within 12 months of the termination of the Contract.

Time of Payment
Claims payable under the Contract for any loss other than loss for which the Contract provides any periodic payment will be processed no later than 30 days after written proof of loss is received. We will notify you and your Provider of any additional information needed to process the claim within this 30 day period.

To Whom Benefits Are Paid
It is not required that the service be provided by a specific Dentist. Payment for services provided by a Dentegra Provider will be made directly to the Dentist. Any other payments provided by the Contract will be made to you, unless he/she requests when filing a proof of claim that the payment be made directly to the dentist providing the services. All Benefits not paid to the Provider will be payable to you, the Primary Enrollee or Dependent Enrollee, or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his/her parent, guardian or other person actually supporting him/her.

Misstatements on Application; Effect
In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract, all statements made by you or the Contractholder will be deemed representations and not warranties. No such statement will be used in defense to a claim under the Contract, unless it is contained in a written application.

Any misrepresentation, omission, concealment of fact or incorrect statement made with intent to deceive which is material to the acceptance of risk may prevent recovery if, had the true facts been known to us, we would not in good faith have issued the contract at the same Premium rate. If any misstatement would materially affect the rates, we reserve the right to adjust the Premium to reflect your actual circumstances at enrollment.

Legal Actions
No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the Contract, nor will an action be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Conformity With Prevailing Laws
All legal questions about the Contract will be governed by the state of Tennessee where the Contract was entered into and is to be performed. Any part of the Contract which conflicts with the laws of Tennessee or federal law is hereby amended to conform to the minimum requirements of such laws.

ADDITIONAL DEFINITIONS FOR PEDIATRIC BENEFITS

Terms when capitalized in the Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Contract Benefit Level -- the percentage of the Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment A.

Deductible -- a dollar amount that a Pediatric Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits as shown in Attachment A.

Eligible Pediatric Enrollee: a person eligible for Benefits under the Contract.

Employee: an individual employed by the Contractholder and who has opted to cover his/her child(ren) under the Contract.

Out-of-Pocket Maximum: the maximum amount a Pediatric Enrollee must satisfy for covered dental services during the Calendar Year provided a Dentegra Provider is used. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Provider even after the Out-of-Pocket Maximum has been met. The Out-of-Pocket Maximum for Dentegra Providers is shown in Attachment A.

Patient Pays: the financial obligation for a Pediatric Enrollee for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as “Dentegra Pays” on the claims statement when a claim is processed.

Pediatric Enrollee: an Eligible Pediatric Enrollee enrolled in the plan to receive Benefits; may also be referred to as “Enrollee”.

Pediatric Enrollee’s Effective Date of Coverage: the date the [Contractholder[DS17]/MPI] reports coverage will begin for each Pediatric Enrollee.

ELIGIBILITY AND ENROLLMENT FOR PEDIATRIC BENEFITS

Eligible Pediatric Enrollee

Eligible Pediatric Enrollees are dependent children of Employees to whom Contractholder offers coverage. Such dependent children are eligible for Benefits under the Contract from birth to age 26.

Dependent children include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by the applicable state regulations and as may be recognized by the Contractholder.

Pediatric Enrollees serving on active military duty are not eligible.

Enrollment of Eligible Pediatric Enrollees

The [Contractholder[DS18]/MPI] is responsible for establishing Pediatric Enrollee’s Effective Date of Coverage for enrollment. . Eligible Pediatric Enrollees must be enrolled within [31[d19]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS20] Pediatric Enrollees who enroll in the Contractholder’s medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

Coverage will terminate when a Pediatric Enrollee loses dependent status or reaches age 26.

Continuation of Benefits

We will not pay for any services/treatment received after the Pediatric Enrollee’s coverage ends. However, we will pay for covered services incurred while he/she were eligible if the procedures were completed within 31 days of the date his/her coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence
Pediatric Enrollees will not be covered for any dental services received while the Employee is on strike, lay-off, leave of absence, other than as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Coverage will resume the first day of the month after the Employee returns to work, provided the Contractholder submits the requests to [Dentegra[DS21]/the MPI] that coverage be reactivated.

Benefits for Pediatric Enrollees will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and Out-of-Pocket Maximums will resume for the Pediatric Enrollee as if the Employee was never gone.

If coverage is reactivated in a different Calendar Year, new Deductibles and Out-of-Pocket Maximums will apply.

If an Employee is rehired within the same Calendar Year, Deductibles and Out-of-Pocket Maximums for the Pediatric Enrollee will resume as if the Employee was never gone.

*Coverage for Pediatric Enrollees is not affected if the Employee takes a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If the Employee is currently paying any part of the premium, he/she may choose to continue coverage. If the Employee does not continue coverage during the leave, he/she can resume coverage for Pediatric Enrollees on their return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act does not apply to all companies, only those that meet certain size guidelines. See the Human Resources Department for complete information.

Continuation of Coverage Under COBRA
COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for the Pediatric Enrollee who loses employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA.

CHOICE OF PROVIDER FOR PEDIATRIC BENEFITS

Pediatric Enrollees may choose a Provider from Dentegra's panel of PPO Providers or Pediatric Enrollees may choose a Non-Dentegra Provider. A list of Providers can be obtained by accessing the Dentegra Provider Directory at [dentegra.com]. A representative can provide specific Provider information over the phone or by mail. Pediatric Enrollees are responsible for verifying whether the selected Provider is a Dentegra Provider. Additionally, Pediatric Enrollees should always confirm with the Provider's office that a listed Provider is still a participating Dentegra Provider. Dentegra does not guarantee that any particular Provider will be available.

Dentegra Provider

Selecting a Dentegra Provider potentially allows the greatest reduction in Pediatric Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon. Also, the services received from a Dentegra Provider apply towards the Out-of-Pocket Maximum limiting a Pediatric Enrollee's out-of-pocket costs to the amount shown in Attachment A.

Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged to Pediatric Enrollees may be above that accepted by the Dentegra Providers, and Pediatric Enrollees will still be responsible for Coinsurance and other cost-sharing, including balance billed amounts, after the Out-of-Pocket Maximum is met. Costs incurred by the patient with a Non-Dentegra Provider do not count towards the Out-of-Pocket Maximum. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

Additional advantages of using a Dentegra Provider:

- The Dentegra Provider must accept assignment of Benefits, meaning Dentegra Providers will be paid directly by Dentegra after satisfaction of the Deductible and Coinsurance, and the Pediatric Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra Provider's Contracted Fee.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

ADDITIONAL DEFINITIONS FOR ADULT BENEFITS

Terms when capitalized in the Evidence of Coverage booklet have defined meanings, given in the section below or throughout the booklet sections.

Contract Benefit Level: percentage of Maximum Contract Allowance that Dentegra will pay after the Deductible has been satisfied as shown in Attachment C.

Deductible: a dollar amount that an Enrollee and/or Dependent Enrollee must satisfy for certain covered services before Dentegra begins paying Benefits.

Dependent Enrollee: an Eligible Dependent enrolled to receive Benefits; may also be referred to as "Enrollee".

Eligible Dependent: an Eligible Dependent enrolled to receive Benefits.

Eligible Employee: any employee eligible for Benefits.

Enrollee's Effective Date of Coverage: the date the [Contractholder[DS22]/MPI] reports coverage will begin for each Enrollee.

Patient Pays: Enrollee's financial obligation for services calculated as the difference between the amount shown as the Accepted Fee and the portion shown as "Dentegra Pays" on the claims statement when a claim is processed.

Primary Enrollee: an Eligible Employee enrolled in the plan to receive Benefits; may also be referred to as "Enrollee".

Spouse: a person related to or a partner of the Eligible Employee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered;
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Eligible Employee resides; and

- as may be recognized by the Contractholder.

ELIGIBILITY AND ENROLLMENT FOR ADULT BENEFITS

Eligible Employees

Employees of Contractholder to whom Contractholder offers coverage.

Eligible Dependents

Eligible Dependents are the Spouse and dependent children to age 26. [Additionally, [D23]children from birth to age 19 are covered for services not covered under the Pediatric Benefits.] Dependent children of the Eligible Employee include natural children, stepchildren, foster children, adopted children, children placed for adoption and children of a partner as required by the applicable state regulations and as may be recognized by the Contractholder.

A dependent unmarried child 26 years of age or older may continue eligibility if:

- he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;
- he or she is chiefly dependent on the Eligible Employee or Spouse for support; and
- proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year following a two year period after this dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on the Eligible Employee or Spouse for support because of a mental or physical disability that began before he or she reached the limiting age.

Dependents serving on active military duty are not eligible.

Enrollment of Eligible Employees and/or Dependent Enrollees

The [Contractholder[DS24]/MPI] is responsible for establishing the Enrollee's Effective Date of Coverage for enrollment. Eligible Enrollees must be enrolled within [31[d25]] days after the date becoming eligible or during an Open Enrollment Period. Coverage may not be changed at any time other than during an Open Enrollment Period or if there is a Qualifying Status Change].

[Eligible[DS26] Employees and/or Dependent Enrollees who enroll in the Contractholder's medical plan through the MPI are required to enroll under this dental plan. Enrollment for coverage under this dental plan begins on the date enrollment under the medical plan begins and terminates on the date enrollment under the medical plan terminates.]

Continuation of Benefits

We will not pay for any services/treatment received after the Enrollee's coverage ends. However, we will pay for covered services incurred while he/she was eligible if the procedures were completed within 31 days of the date your coverage ended.

A dental service is incurred:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Strike, Lay-off and Leave of Absence

Enrollees will not be covered for any dental services received while the Eligible Employee is on strike, lay-off, leave of absence, other than [an approved leave of absence or] as required under the Family & Medical Leave Act of 1993 or other applicable state or federal law*.

Coverage will resume the first day of the month after the Eligible Employee returns to work, provided the Contractholder submits the requests to [Dentegra[DS27]/the MPI] that coverage be reactivated.

Benefits for Enrollees will resume as follows:

- If coverage is reactivated in the same Calendar Year, Deductibles and maximums will resume as if you were never gone; or
- If coverage is reactivated in a different Calendar Year, new Deductibles and maximums will apply.

If the Eligible Employee is rehired within the same Calendar Year, Deductibles and Maximums will resume as if the Eligible Employee were never gone.

*Coverage for Enrollees is not affected if the Eligible Employee takes a leave of absence allowed under the Family & Medical Leave Act of 1993 or other applicable state or federal law. If the Eligible Employee is currently paying any part of your Premium, you may choose to continue coverage. If the Eligible Employee does not continue coverage during the leave, you can resume that coverage for Enrollees on their return to active work as if no interruption occurred.

Important: The Family & Medical Leave Act does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

Continued Coverage under USERRA

As required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if the Primary Enrollee is covered by the Contract on the date his or her USERRA leave of absence begins, the Primary Enrollee may continue dental coverage for himself or herself and any covered dependents. Continuation of coverage under USERRA may not extend beyond the earlier of:

- 24 months, beginning on the date the leave of absence begins, or;
- the date the Primary Enrollee fails to return to work within the time required by USERRA.

For USERRA leave that extends beyond 31 days, the Premium for continuation of coverage will be the same as for COBRA coverage.

Continuation of Coverage Under COBRA

COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) provides a way for you and your Dependent Enrollees who lose employer-sponsored group health plan coverage to continue coverage for a period of time. COBRA does not apply to all companies, only those that meet certain size guidelines. See your Human Resources Department for complete information.

We do not assume any of the obligations required by COBRA of the Contractholder or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA.

CHOICE OF PROVIDER FOR ADULT BENEFITS

Enrollees may choose a Provider from Dentegra's panel of PPO Providers or Enrollees may choose a Non-Dentegra Provider. A list of Dentegra Providers can be obtained at Dentegra's website [(dentegra.com)]. Providers are regularly added to or deleted from the list. Enrollees are responsible for verifying whether the selected Provider is a PPO Provider. Additionally, Enrollees should always confirm with the Provider's office that a listed Provider is still a participating Dentegra Provider.

Dentegra Provider

Selecting a Dentegra Provider potentially allows the greatest reduction in Enrollees' out-of-pocket expenses, since this select group of Providers will provide dental Benefits at a charge which has been contractually agreed upon.

Non-Dentegra Provider

If a Provider is a Non-Dentegra Provider, the amount charged to Enrollees may be above that accepted by the Dentegra Providers. For a Non-Dentegra Provider, the Accepted Fee is the Provider's Submitted Fee.

Additional advantages of using a Dentegra Provider:

- The Dentegra Provider must accept assignment of Benefits, meaning Dentegra Providers will be paid directly by Dentegra after satisfaction of the Deductible and coinsurance, and the Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- The Dentegra Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and Dentegra Provider's Contracted Fee.
- The Dentegra Provider will complete the dental Claim Form and submit it to Dentegra for reimbursement.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
(2) the insurer was not authorized to do business in this state;
(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) any policy of reinsurance (unless an assumption certificate was issued);
(3) interest rate yields that exceed an average rate;
(4) dividends;
(5) credits given in connection with the administration of a policy by a group contract holder;
(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
(7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association 150 3rd Avenue South, Suite 1600 Nashville, TN 37201

Tennessee Department of Commerce and Insurance 500 James Robertson Parkway Nashville,Tennessee 37243

NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY OF YOUR HEALTH CARE INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required by law to tell you how Dentegra protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Dentegra receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, we may change this notice and make the new notice effective for all of your PHI that we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Dentegra program, and we will notify you of how you can receive a copy of this notice every three years.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or that sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for Dentegra in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate. These affiliates have also implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we are permitted to use and/or disclose your PHI for underwriting. We are also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.

  For example, Dentegra may use or disclose your PHI to determine eligibility for services requested by your provider.
- Uses and/or disclosures of PHI for payment.

  For example, Dentegra may use and disclose your PHI to bill you or your plan sponsor.
- Uses and/or disclosures of PHI for health care operations.

  For example, Dentegra may use and disclose your PHI to review the quality of care provided by our network of providers.

Disclosures Without an Authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law. Dentegra may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations.

Disclosures Dentegra Makes With Your Authorization

Dentegra will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Dentegra or by a person requesting your PHI from Dentegra.

Your Rights Regarding PHI

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting the appropriate Dentegra office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Dentegra may charge a reasonable fee for providing you copies of your PHI. Dentegra will only maintain that PHI that we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by Dentegra to the Dentist after we have completed our review of that information. You may need to contact your health care provider to obtain PHI that Dentegra does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to correct or update your PHI. This means that you may request an amendment of PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to us by another, we may refer you to that person to amend your PHI. For example, we may refer you to your Dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information we disclosed after we received a valid authorization from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to get this notice by email. You have the right to get a copy of this notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice.

Complaints

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Dentegra has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint.

Contact

You may contact the Privacy Department at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Address: Dentegra Insurance Company
[P.O. Box 1850
Alpharetta, GA 30023-1850]

Phone: [877-280-4204]

This notice is effective on and after August 1, 2012

Variable Form with Comments 6-12-13

OXGE-TN-DIC (Clean 6-12-13).docx

Main document changes and comments

Page 1: Comment [D1] **Courtney Rozear (ga24413)** **6/13/2013 3:16:00 PM**

Logo for State or Partner will be inserted here if required.

Page 1: Comment [D2] **Courtney Rozear (ga24413)** **6/13/2013 3:16:00 PM**

This field will be updated with the plan name to be issued.

Page 1: Comment [D3] **Courtney Rozear (ga24413)** **6/13/2013 3:16:00 PM**

This field will be updated with the plan name to be issued.

Page 1: Comment [DR4] **Denise Reed (ga25409)** **6/13/2013 3:16:00 PM**

Enter Contractholder's name.

Page 1: Comment [DR5] **Denise Reed (ga25409)** **6/13/2013 3:16:00 PM**

Enter Contractholder's group number.

Page 1: Comment [DR6] **Denise Reed (ga25409)** **6/13/2013 3:16:00 PM**

Use the original effective date of the Contract.

Page 1: Comment [DR7] **Denise Reed (ga25409)** **6/13/2013 3:16:00 PM**

Use revised date when there are changes that require a modification/revision to the Evidence of Coverage.

Page 1: Comment [D8] **Courtney Rozear (ga24413)** **6/13/2013 3:16:00 PM**

The website address is filed as variable in case in needs to be updated in the future.

Page 1: Comment [D9] **Courtney Rozear (ga24413)** **6/13/2013 3:16:00 PM**

This information is filed as variable.

Page 1: Comment [D10] **Courtney Rozear (ga24413)** **5/9/2013 9:52:00 PM**

This variable is not standard and used only with underwriting approval.

Page 1: Comment [D11] **Courtney Rozear (ga24413)** **5/7/2013 6:46:00 PM**

Standard is to include this variable as shown. The company's website is shown as variable throughout the document should it need to be updated in the future.

Page 1: Comment [D12] **Eboni Warren (ga28462)** **5/7/2013 6:47:00 PM**

Standard is to include this variable as shown. The company's phone number is shown as variable throughout this document should the information change in the future.

Page 1: Comment [D13] **Eboni Warren (ga28462)** **5/7/2013 6:47:00 PM**

Standard is to include this variable as shown. The company's address is shown as variable should the information change in the future.

Page 2: Comment [DS14] **Debbie Shealy (ga62861)** **5/7/2013 6:19:00 PM**

Include this definition only if bundled with MPI otherwise delete.

Page 2: Comment [DS15] **Debbie Shealy (ga62861)** **5/7/2013 6:21:00 PM**

Select employer if there is not a bundled arrangement and MPI if there is a bundled arrangement.

Page 2: Comment [DS16] **Debbie Shealy (ga62861)** **5/7/2013 6:23:00 PM**

Include this definition only if bundled with MPI otherwise delete.

Page 9: Comment [DS17] **Debbie Shealy (ga62861)** **5/7/2013 6:25:00 PM**

Select entity based on who is responsible for eligibility.

Page 9: Comment [DS18] **Debbie Shealy (ga62861)** **5/7/2013 6:26:00 PM**

Variable Form with Comments 6-12-13

Select entity based on who is responsible for eligibility.

Page 9: Comment [d19] **Courtney Rozear (ga24413)** **5/8/2013 12:10:00 PM**

The time to enroll may be increased at the Contractholder's request with Underwriting approval up to 180 days.

Page 9: Comment [DS20] **Debbie Shealy (ga62861)** **5/7/2013 6:28:00 PM**

Include if bundled with MPI otherwise delete.

Page 10: Comment [DS21] **Debbie Shealy (ga62861)** **5/7/2013 6:40:00 PM**

Select entity responsible for eligibility.

Page 11: Comment [DS22] **Debbie Shealy (ga62861)** **5/7/2013 6:41:00 PM**

Select entity responsible for eligibility.

Page 12: Comment [D23] **Courtney Rozear (ga24413)** **5/9/2013 10:02:00 PM**

This variable is not standard and used only with underwriting approval.

Page 12: Comment [DS24] **Debbie Shealy (ga62861)** **5/7/2013 6:34:00 PM**

Select Contractholder or MPI depending on who is responsible for eligibility reporting.

Page 12: Comment [d25] **Courtney Rozear (ga24413)** **5/7/2013 6:34:00 PM**

The time to enroll may be increased at the Contractholder's request with Underwriting approval up to 180 days.

Page 12: Comment [DS26] **Debbie Shealy (ga62861)** **5/7/2013 6:34:00 PM**

Include if bundled with MPI otherwise delete.

Page 12: Comment [DS27] **Debbie Shealy (ga62861)** **5/7/2013 6:48:00 PM**

Select entity responsible for eligibility.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

Attachment A
Deductibles, Maximums and Contract Benefit Levels
Dentegra Dental PPO
Children's Plan 85

Deductibles & Maximums	
Annual Deductible	$25 per Pediatric Enrollee each Calendar Year The annual Deductible is waived for Diagnostic and Preventive Services.
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Pediatric Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers*	
Individual	$700 each Calendar Year
Multiple Child	$1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount a Pediatric Enrollee must satisfy for covered dental services under the Contract during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If an Employee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO Providers†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Medically Necessary Orthodontic Services (requires Prior Authorization)	50%	50%

†Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

Variable Form with Comments 6-5-13

OPGAtAhi-TN-DIC (Clean 6-5-13).docx

Main document changes and comments

Page 1: Comment [D1] **Courtney Rozear (ga24413)** **2/4/2013 12:27:00 AM**

Include Deductible Takeover if Contractholder has prior group coverage and Effective Date is other than January 1st.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

Attachment A
Deductibles, Maximums and Contract Benefit Levels
Dentegra Dental PPO
Children's Plan 70

Deductibles & Maximums	
Annual Deductible	$45 per Pediatric Enrollee each Calendar Year
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Pediatric Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Out-of-Pocket Maximum for Dentegra PPO℠ Providers*	
Individual	$700 each Calendar Year
Multiple Child	$1,400 each Calendar Year

- The annual Out-of-Pocket Maximum is the maximum amount a Pediatric Enrollee must satisfy for covered dental services under the Contract during a Calendar Year provided Dentegra PPO Providers are used. Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Non-Dentegra Providers even after the Out-of-Pocket Maximum is met.

  If an Employee covers more than one Pediatric Enrollee, the financial obligation for covered services received from Dentegra PPO Providers is not more than the multiple child annual Out-of-Pocket Maximum. After a Pediatric Enrollee meets his or her individual annual Out-of-Pocket Maximum, a Pediatric Enrollee will not have to pay Coinsurance for the rest of the Calendar Year for covered services received from Dentegra PPO Providers. Other covered Pediatric Enrollees must continue to pay Coinsurance for covered services received from Dentegra PPO Providers until the total amount paid reaches the multiple child annual Out-of-Pocket Maximum. Once the amount paid by all Pediatric Enrollees equals the multiple child annual Out-of-Pocket Maximum, no further payment will be required by any of the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from Dentegra PPO Providers.

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO Providers†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic and Preventive Services	100%	100%
Basic Services	50%	50%
Major Services	50%	50%
Medically Necessary Orthodontic Services (requires Prior Authorization)	50%	50%

†Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

Variable Form with Comments 6-5-13

OPGAtAlo-TN-DIC (Clean 6-5-13).docx

Main document changes and comments

Page 1: Comment [D1] **Courtney Rozear (ga24413)** **2/4/2013 12:27:00 AM**

Include Deductible Takeover if Contractholder has prior group coverage and Effective Date is other than January 1st.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

Attachment B
Services, Limitations and Exclusions
Dentegra Dental PPO
Children's Plan [85/70][D1]

Description of Dental Services

Dentegra will pay or otherwise discharge the Contract Benefit Level shown in Attachment A for the services shown on Attachment B-1 when provided by a Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthdontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a Prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.

Limitations

(1) Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

(2) Claims shall be processed in accordance with Dentegra's standard processing policies. The processing policies may be revised from time to time; therefore, Dentegra shall use the processing policies that are in effect at the time the claim is processed. Dentegra may use dentists (dental consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

(3) If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

(4) Dentegra will pay for oral examinations (except exams for observation) no more than twice in a Calendar Year. Only one (1) comprehensive evaluation is allowed in a Calendar Year and counts toward the oral examination frequency in the year provided. One (1) limited oral evaluation, problem-focused no more than once in a Calendar Year.

(5) X-ray limitations:

a) Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
b) When a panoramic film is submitted with supplemental film(s), Dentegra will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.
c) If a panoramic film is taken in conjunction with an intraoral complete series, Dentegra considers the panoramic film to be included in the complete series.
d) A complete intraoral series and panoramic film are each limited to once every 60 months.
e) Bitewing x-rays are limited to two (2) times in a Calendar Year. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

(6) Dentegra will pay for routine cleanings and topical application of fluoride solutions no more than twice in a Calendar Year, and periodontal cleanings in the presence of inflamed gums up to four (4) times in a Calendar Year. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings not to exceed four (4) procedures or any combination thereof in a Calendar Year. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

(7) Space maintainer limitations:

a) Space maintainers are limited to the initial appliance.
b) Recementation of space maintainer is limited to once per lifetime.

c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

(8) Sealants are limited as follows:
a) to permanent molars through age 18 if they are without caries (decay) or restorations on the occlusal surface.
b) do not include repair or replacement of a Sealant on any tooth within 36 months of its application.

(9) Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.

(10) Dentegra will not cover to replace an amalgam or resin-based composite within 24 months of treatment if the service is provided by the same Provider/Provider office. Pefabricated stainless steel crowns are limited to once per Enrollee per tooth per lifetime. Replacement restorations within 24 months are included in the fee for the original restoration.

(11) Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 15.

(12) Therapeutic pulpotomy is limited to once per lifetime for baby (deciduous) teeth only. It is a benefit for primary incisor teeth up to age six (6) and for primary molars and cuspids to age 11.

(13) Root canal therapy and pulpal therapy (resorbable filling) are limited to once in a lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

(14) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth of one (1) initial visit, four (4) interim visits and one (1) final visit to age 19.

(15) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

(16) Retrograde fillings per root are limited to once in any 24-month period.

(17) Pin retention is covered not more than once in any 24-month period.

(18) Palliative treatment is covered per visit, not per tooth, and the fee includes all treatment provided other than required x-rays or select Diagnostic procedures.

(19) Period ontal limitations:
a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
b) Periodontal surgery in the same quadrant is limited to once in every 24-month period and includes any surgical re-entry or scaling and root planing.
c) Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d) If in the same quadrant, scaling and root planing must be performed at least six (6) weeks prior to the periodontal surgery.
e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
f) One crown lengthening per tooth per lifetime.

(20) Oral Surgery services are covered once in a lifetime except removal of cysts and lesions and incision and drainage procedures, which are covered once in the same day.

(21) Crowns and Inlays/Onlays are limited to Enrollees age 12 and older and are covered not more often than once in any 60 month period except when Dentegra determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues.

(22) When an alternate Benefit of an amalgam is allowed for inlays/ onlays, they are limited to Enrollees age 12 and older and are covered not more than once in any 60 month period.

(23) Core buildup, including any pins, are covered not more than once in any 60 month period.

(24) Post and core services are covered not more than once in any 60 month year period.

(25) Crown repairs are covered not more than once in any 60 month period.

(26) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

(27) Denture Repairs are covered not more than once in any six (6) month period except for fixed Denture Repairs which are covered not more than once in any 60 month period.

(28) Prosthodontic appliances, implants and/or implant supported prosthetics that were provided under any Dentegra program will be replaced only after 60 months have passed, except when Dentegra determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Fixed prosthodontic appliances are limited to Enrollees age 16 and older. Removable cast base partial dentures are limited to Enrollees age 12 and older. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a Dentegra program will be made if Dentegra determines it is unsatisfactory and cannot be made satisfactory. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Dentegra's payment for implant removal is limited to one (1) for each implant during the Enrollee's lifetime whether provided under Dentegra or any other dental care plan.

(29) When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

(30) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement. After six (6) months, payment will be limited to one (1) recementation in a (6) month period by the same Provider/Provider office.

(31) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a Dentegra plan or Contractholder's prior plan, if applicable

(32) Dentegra limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments and relines for the first six (6) months after placement.
   a) Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
   b) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, adjustments and relining are limited to one (1) per arch in a 36-month period.
   c) Tissue conditioning is limited to two (2) per arch in a 12-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
   d) Recementation of fixed partial dentures is limited to once in a lifetime.

(33) Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period.

(34) Athletic mouth guards are limited to one (1) per 12 consecutive month period.

(35) Internal bleaching of discolored teeth shall not be provided for any tooth more than once each 36 months while the patient is an Enrollee under any Dentegra plan.

Exclusions

Dentegra does not pay Benefits for:

(1) services not included on Attachment B-1 Schedule of Covered Services except medically necessary Orthodontics provided a Prior Authorization is obtained.

(2) treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

(3) cosmetic surgery or procedures for purely cosmetic reasons.

(4) maxillofacial prosthetics.

(5) provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under).

(6) services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

(7) treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.

(8) any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

(9) prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

(10) charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures if such procedures included in Attachment B-1.

(11) extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

(12) laboratory processed crowns for Enrollees under age 12.

(13) fixed bridges and removable partials for Enrollees under age 16.

(14) indirectly fabricated resin-based Inlays/Onlays.

(15) overdentures.

(16) charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

(17) treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

(18) charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

(19) dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

(20) procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

(21) any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

(22) Deductibles and/or any service not covered under the dental plan.

(23) services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

(24) the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan with Dentegra or the Contractholder's prior dental plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

(25) services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

(26) endodontic endosseous implant.

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OPGAtB-TN-DIC (Clean 6-5-13).docx

Main document changes and comments

Page 1: Comment [D1] **Eboni Warren (ga28462)** **4/16/2013 11:28:00 AM**

Insert the applicable plan number at time of issue.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

ATTACHMENT E
GROUP VARIABLES
[Information in this section is variable.]
for
[Contractholder*[D1] *Name]
[Group Number]

Effective Date:

Contract Term:

Premiums:
Monthly Amount:

[Per[D2] Primary Enrollee:	$	[XX]
Per Primary Enrollee and his/her Dependent Enrollee(s):**]**	$	[XX][D3]

Premiums are to be remitted to:

[[SF4]**Dentegra Insurance Company**
[[SF5]P.O. Box 1850
Alpharetta, GA 30023-1850]

[MPI][D6]
Street Address line 1
Street Address line 2
City, State Zip]

Payment Breakdown:

Contractholder shall pay:	[0-100]	%	for Employee
	[0-100][D7]	%	for Dependent Enrollees
Primary Enrollee shall pay:	[0-100]	%	for Employee
	[0-100][D8]	%	for Dependent Enrollees

Contractholder may charge persons electing continued coverage pursuant to Title X of P.L. 99 as permitted by law.

OXGAtE-TN-DIC (Clean 6-12-13).docx

Main document changes and comments

Page 1: Comment [D1] **Courtney Rozear (ga24413)** **6/12/2013 10:01:00 AM**

Information will be completed for Contractholder Name, group number, effective date and Contract Term.

Page 1: Comment [D2] **Courtney Rozear (ga24413)** **6/12/2013 10:01:00 AM**

Rate tier variable to be completed when issued.

Page 1: Comment [D3] **Courtney Rozear (ga24413)** **6/12/2013 10:01:00 AM**

Premium amount to be completed when issued.

Page 1: Comment [SF4] **Sharon Ford (ga31755)** **6/12/2013 10:01:00 AM**

Include if standalone – no bundled arrangement; otherwise, delete.

Page 1: Comment [SF5] **Sharon Ford (ga31755)** **6/12/2013 10:01:00 AM**

The company's address is variable should it need to be updated in the future.

Page 1: Comment [D6] **Eboni Warren (ga28462)** **6/12/2013 10:01:00 AM**

Include this address only if bundled; otherwise, delete.

Page 1: Comment [D7] **Courtney Rozear (ga24413)** **6/12/2013 10:01:00 AM**

Percentage to be contributed by Contractholder.

Page 1: Comment [D8] **Courtney Rozear (ga24413)** **6/12/2013 10:01:00 AM**

Percentage to be contributed by Contractholder's employee.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

Attachment C
Deductibles, Maximums and Contract Benefit Levels for Adult Benefits
Dentegra Dental PPO
Adult Basic

Deductibles & Maximums	
Annual Deductible	$50 per Enrollee each Calendar Year $150 per family each Calendar Year
Deductibles waived for	Diagnostic & Preventive
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Maximum	$1,000 per Enrollee per Calendar Year
[Annual Maximum Takeover	Dentegra will receive credit for any amount paid under the Contractholder's previous dental care plan from January 1st to the Effective Date. These amounts will be credited towards the Annual Maximum.]

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO℠ Provider†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic & Preventive	100%	100%
Basic Services	80%	80%

† Reimbursement is based on Dentegra PPO Contracted Fee for Dentegra PPO and Non-Dentegra Providers.

OXGAtClo-TN-DIC (Clean 6-10-13).docx

Main document changes and comments

Page 1: Comment [D1] **Courtney Rozear (ga24413)** **2/14/2013 4:57:00 PM**

Include this row when Deductible takeover applies; otherwise, delete.

Header and footer changes

Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

Attachment C
Deductibles, Maximums and Contract Benefit Levels for Adult Benefits
Dentegra Dental PPO
Adult Preferred

Deductibles & Maximums	
Annual Deductible	$50 per Enrollee each Calendar Year $150 per family each Calendar Year
Deductibles waived for	Diagnostic & Preventive
[Deductible[D1] Takeover	Any annual Deductible amount satisfied by the Enrollees under the Contractholder's previous dental care plan from January 1st to the Effective Date will be credited towards the annual Deductible under the Contract.]
Annual Maximum	$1,000 per Enrollee per Calendar Year
[Annual [D2]Maximum Takeover	Dentegra will receive credit for any amount paid under the Contractholder's previous dental care plan from January 1st to the Effective Date. These amounts will be credited towards the Annual Maximum.]
Dental Accident Maximum	$1,000 per Enrollee per lifetime
[Dental[D3] Accident Maximum Takeover	Dentegra will receive credit for any amount paid under the Contractholder's previous dental care plan, if applicable, for Dental Accident Services. These amounts will be credited towards the maximum amounts payable for Dental Accident Services.]

Contract Benefit Levels		
Dental Service Category	**Dentegra PPO℠ Provider†**	**Non-Dentegra Providers†**
Dentegra will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for the following services:		
Diagnostic & Preventive	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Dental Accident	100%	100%

† Reimbursement is based on Dentegra PPO Contracted Fees for Dentegra PPO and Non-Dentegra Providers.

Waiting Periods:

- Major Services are limited to Enrollees who have been enrolled in the Contract for 12 consecutive months. Waiting periods are calculated for each Primary Enrollee and/or Dependent Enrollee from the Effective Date of Coverage reported by the Exchange for said Primary Enrollee and/or Dependent Enrollee.

Variable Form with Comments 6-12-13

OXGAtChi-TN-DIC (Clean 6-10-13).docx

Main document changes and comments

Page 1: Comment [D1] **Courtney Rozear (ga24413)** **2/14/2013 4:57:00 PM**

Include this row when Deductible takeover applies; otherwise, delete.

Page 1: Comment [D2] **Courtney Rozear (ga24413)** **4/11/2013 4:54:00 PM**

Include this row if Annual Maximum takeover applies; otherwise, delete.

Page 1: Comment [D3] **Courtney Rozear (ga24413)** **4/11/2013 5:06:00 PM**

Include this row if Dental Accident Maximum takeover applies; otherwise, delete.

Header and footer changes

Page 1: Inserted **Sharon Ford (ga31755)** **6/14/2013 2:51:00 PM**

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Text Box changes

Header and footer text box changes

Footnote changes

Endnote changes

DENTEGRA Insurance Company

www.dentegra.com

Readability Certification

As an authorized representative of the company, we have reviewed the enclosed policy forms and certify that, to the best of our knowledge and belief, each form submitted meets your state's minimum statutory requirements relating to the readability of said forms.

Dick Aracich	Vice President, Sales
Name	Title
Signature	6-11-13
	Date

Corporate Headquarters
100 First Street San Francisco CA 94105
Telephone 866-238-1580

GROUP RATE CERTIFICATION

Please check one or both of the boxes to indicate the type of rate methodology which will be used with this form. If you check only the first box you are certifying that the rates are based solely on the claims experience of a single group policyholder, not the insurance company's experience.
Please have the actuary preparing this document sign the certification below.
This must be an actual signature, not computer generated or rubber stamped.

☐As to experience-rated group insurance, premium rates and classifications need not be filed, however, form filings must be certify by signing below (i) the policy filing is experience-rated group insurance, and (ii) the premium rates and classification of risks are available for review by the Commissioner of Insurance upon request.

☒As to other than experience-rated group insurance, the applicable premium rates and classifications must accompany the form filing, and the filing must certify by signing below that the premium rates are not unreasonable in relation to benefits provided, and that actuarial data and experience shall be maintained by the company and available for review by the Commissioner of Insurance upon request.

Signature

Print name Thomas J. Leibowitz, FSA, MAAA

Title Vice President and Chief Actuary

GROUP RATE CERTIFICATION

Please check one or both of the boxes to indicate the type of rate methodology which will be used with this form. If you check only the first box you are certifying that the rates are based solely on the claims experience of a single group policyholder, not the insurance company's experience.
Please have the actuary preparing this document sign the certification below.
This must be an actual signature, not computer generated or rubber stamped.

☐As to experience-rated group insurance, premium rates and classifications need not be filed, however, form filings must be certify by signing below (i) the policy filing is experience-rated group insurance, and (ii) the premium rates and classification of risks are available for review by the Commissioner of Insurance upon request.

☒As to other than experience-rated group insurance, the applicable premium rates and classifications must accompany the form filing, and the filing must certify by signing below that the premium rates are not unreasonable in relation to benefits provided, and that actuarial data and experience shall be maintained by the company and available for review by the Commissioner of Insurance upon request.

Signature

Print name Thomas J. Leibowitz, FSA, MAAA

Title Vice President and Chief Actuary

ACTUARIAL MEMORANDUM
Dentegra Insurance Company
State of Tennessee
May 22, 2013

Form Number PGC-TN-DIC

1. **Scope and Purpose of Filing**
   This filing is for the above Dentegra Insurance Company (DIC) forms.

2. **Description of Benefits**

   The pediatric dental EHB are defined in Attachment A and cover essential health benefit services as defined by the state. These comply with the actuarial value requirements for the high and low EHB plans.

3. **Renewability**
   All small group dental programs are optionally renewable. Premiums are guaranteed for each 12-month contract term.

4. **Applicability**
   DIC anticipates both new issues and renewals under these forms.

5. **Morbidity**
   The proposed rates were developed using the Delta Dental Insurance Company (DDIC), NAIC #81396, rating manual, which is currently in use in numerous states. Adjustments have been made to reflect the fee schedules and area definitions associated with this filing.

6. **Mortality**
   Not applicable.

7. **Persistency**
   Loss ratios are expected to be consistent over time. As a result, there are no lapse assumptions.

8. **Expenses**

   Expenses are shown in Attachment B. Co-marketing in conjunction with a medical plan, may require a change in administrative assumptions due to division of labor between medical and dental, cost sharing, etc.

9. **Marketing Method**
   This will be sold to small groups through the Tennessee health exchange or through agents and brokers inside or outside the exchange.

10. **Underwriting**

The plans are manually rated.

11. **Premium Classes**
Gross premiums vary by plan designs illustrated in Attachment A.

12. **Issue Age Range**
Not applicable.

13. **Area Factors**
Manual rates are statewide.

14. **Premium Modalization Rules**
Not applicable since this is a new plan offering.

15. **Claim Liability and Reserves**
This reserve is projected from historical claims runoff, using a common reserving methodology.

16. **Active Life Reserves**
Not applicable since this is a new plan offering.

17. **Trend Assumptions**
The annual cost trend rate is 4%.

18. **Anticipated Loss Ratio**
The anticipated loss ratio is shown in Attachment B.

19. **Distribution of Business**
Not applicable since this is a new plan offering.

20. **Contingency and Risk Margins**
Risk margin is shown in Attachment B.

21. **Experience**
Please see Attachment C for DDIC small group experience.

22. **Lifetime Loss Ratio**
The lifetime loss ratio is equal to the anticipated loss ratio.

23. **Number of Policyholders**
Not applicable since this is a new plan offering.

24. **Proposed Effective Date**
01/01/2014.

25. Actuarial Certification

I, Thomas J. Leibowitz, FSA, MAAA, am a member of the American Academy of Actuaries, and meet the Academy Qualification Standard for rendering this Opinion.

I have reviewed the actuarial assumptions and methods on which the rates are based. I hereby certify that to the best of my knowledge and judgment, this rate filing is in compliance with the applicable laws and regulations of the state of Tennessee and complies with Actuarial Standard of Practice No. 8. The rates shown are

- Based on actuarially sound principles
- Are not inadequate, excessive or unfairly discriminatory, and
- Are reasonable in relation to the benefits provided.

Thomas J. Leibowitz, FSA, MAAA
Vice President and Chief Actuary
Dentegra Insurance Company
One First Street
San Francisco, CA 94105

Attachment A

Tennessee Small Group Pediatric Dental Benefits

PPO/PPO	Pediatric High	Pediatric Low
Diagnostic & Preventive	100%	100%
Basic Services	80%	50%
Major Services	50%	50%
Orthodontics (Medically Necessary)	50%	50%
Deductible		
Waived on D&P	yes	no
Per Person	$25	$45
Family	n/a	n/a
Annual Maximum	None	None
Othodontics Maximum (Lifetime)	None	None
Waiting Periods (Major & Ortho)	None	None
Out of Pocket Maximum (PPO dentists only)		
per child	$700	$700
per 2+ children	$1,400	$1,400
Dental Accident Benefits	NAB*	NAB*
Rates: Statewide	$32.60	$26.25

* NAB is not a benefit

Note: Covered procedures are defined in the forms

Attachment B

Tennessee Small Group Administrative Expenses (as a percent of premium)

	Pediatric High	Pediatric Low
Admin Expenses	22.50%	22.50%
Risk Margin	3.50%	1.00%
Premium Tax	2.50%	2.50%
ACA Tax	2.00%	2.00%
TPA Admin	0.00%	0.00%
Commissions	7.50%	7.50%
Total	38.00%	35.50%
Anticipated Loss Ratio **	64.92%	67.54%

** Anticipated Loss Ratio = (1 - Total) / (1 - Premium Tax - ACA Tax)

Attachment C
DDIC Small Group Experience

	CY2012
Number of Policy Holders	2,881
Number of Certificate Holders	38,308
Earned Premium	$24,525,709
Average Annual Premium	$640
Incurred Claims	$16,016,000
Number of Incurred Claims	124,033
Incurred Loss Ratio	65.3%

ACTUARIAL MEMORANDUM
Dentegra Insurance Company
State of Tennessee
May 22, 2013

Form Number XGC-TN-DIC

1. **Scope and Purpose of Filing**
   This filing is for the above Dentegra Insurance Company (DIC) forms.

2. **Description of Benefits**
   The Supplemental dental plans are defined in Attachment A and cover standardly covered services.

3. **Renewability**
   All small group dental programs are optionally renewable. Premiums are guaranteed for each 12-month contract term.

4. **Applicability**
   DIC anticipates both new issues and renewals under these forms.

5. **Morbidity**
   The proposed rates were developed using the Delta Dental Insurance Company (DDIC), NAIC #81396, rating manual, which is currently in use in numerous states. Adjustments have been made to reflect the fee schedules and area definitions associated with this filing.

6. **Mortality**
   Not applicable.

7. **Persistency**
   Loss ratios are expected to be consistent over time. As a result, there are no lapse assumptions.

8. **Expenses**

   Expenses are shown in Attachment B. Co-marketing in conjunction with a medical plan, may require a change in administrative assumptions due to division of labor between medical and dental, cost sharing, etc.

9. **Marketing Method**
   This will be sold to small groups through the Tennessee health exchange or through agents and brokers inside or outside the exchange.

10. **Underwriting**
    The plans are manually rated.

11. **Premium Classes**
Gross premiums vary by plan designs illustrated in Attachment A.

12. **Issue Age Range**
Not applicable.

13. **Area Factors**
Manual rates are statewide.

14. **Premium Modalization Rules**
Not applicable since this is a new plan offering.

15. **Claim Liability and Reserves**
This reserve is projected from historical claims runoff, using a common reserving methodology.

16. **Active Life Reserves**
Not applicable since this is a new plan offering.

17. **Trend Assumptions**
The annual cost trend rate is 4%.

18. **Anticipated Loss Ratio**
The anticipated loss ratio is shown in Attachment B.

19. **Distribution of Business**
Not applicable since this is a new plan offering.

20. **Contingency and Risk Margins**
Risk margin is shown in Attachment B.

21. **Experience**
Please see Attachment C for DDIC small group experience.

22. **Lifetime Loss Ratio**
The lifetime loss ratio is equal to the anticipated loss ratio.

23. **Number of Policyholders**
Not applicable since this is a new plan offering.

24. **Proposed Effective Date**
01/01/2014.

25. Actuarial Certification

I, Thomas J. Leibowitz, FSA, MAAA, am a member of the American Academy of Actuaries, and meet the Academy Qualification Standard for rendering this Opinion.

I have reviewed the actuarial assumptions and methods on which the rates are based. I hereby certify that to the best of my knowledge and judgment, this rate filing is in compliance with the applicable laws and regulations of the state of Tennessee and complies with Actuarial Standard of Practice No. 8. The rates shown are

- Based on actuarially sound principles
- Are not inadequate, excessive or unfairly discriminatory, and
- Are reasonable in relation to the benefits provided.

Thomas J. Leibowitz, FSA, MAAA
Vice President and Chief Actuary
Dentegra Insurance Company
One First Street
San Francisco, CA 94105

Attachment A

Tennessee Small Group Supplemental Dental Benefits

PPO/PPO	Pediatric High	Pediatric Low	Adult Preferred	Adult Basic
Diagnostic & Preventive	100%	100%	100%	100%
Basic Services	80%	50%	80%	80%
Major Services	50%	50%	50%	0%
Orthodontics (Medically Necessary)	50%	50%	NAB*	NAB*
Deductible				
Waived on D&P	yes	no	yes	yes
Per Person	$25	$45	$50	$50
Family	n/a	n/a	$150	$150
Annual Maximum	None	None	$1,000	$1,000
Othodontics Maximum (Lifetime)	None	None	NAB*	NAB*
Waiting Periods (Major & Ortho)	None	None	12 mos	None
Out of Pocket Maximum (PPO dentists only)				
per child	$700	$700	NAB*	NAB*
per 2+ children	$1,400	$1,400	NAB*	NAB*
Dental Accident Benefits	NAB*	NAB*	100% w/ $1000 Lifetime Max	NAB*
Rates: Statewide	$32.60	$26.25	$53.73	$33.32

* NAB is not a benefit

Note: Plan combinations and covered procedures are defined in the forms

Attachment B

Tennessee Small Group Administrative Expenses (as a percent of premium)

	Pediatric High	Pediatric Low	Adult Preferred	Adult Basic
Admin Expenses	22.50%	22.50%	22.50%	22.50%
Risk Margin	3.50%	1.00%	3.50%	3.50%
Premium Tax	2.50%	2.50%	2.50%	2.50%
ACA Tax	2.00%	2.00%	2.00%	2.00%
TPA Admin	0.00%	0.00%	0.00%	0.00%
Commissions	7.50%	7.50%	7.50%	7.50%
Total	38.00%	35.50%	38.00%	38.00%
Anticipated Loss Ratio **	64.92%	67.54%	64.92%	64.92%

** Anticipated Loss Ratio = (1 - Total) / (1 - Premium Tax - ACA Tax)

Attachment C
DDIC Small Group Experience

	CY2012
Number of Policy Holders	2,881
Number of Certificate Holders	38,308
Earned Premium	$24,525,709
Average Annual Premium	$640
Incurred Claims	$16,016,000
Number of Incurred Claims	124,033
Incurred Loss Ratio	65.3%